HEALTH CARE IMPROVED ACCESS ACT OF 1986

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

SECOND SESSION

ON

H.R. 4742

TO AMEND THE INTERNAL REVENUE CODE OF 1954 TO ASSURE ACCESS TO HEALTH INSURANCE, AND FOR OTHER PURPOSES

JUNE 9, 1986

Serial 99-87

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HEALTH CARE IMPROVED ACCESS ACT OF 1986

MONDAY, JUNE 9, 1986

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, DC.

The subcommittee met, pursuant to call, at 1:10 p.m., in room B-318, Rayburn House Office Building, Hon. Fortney H. (Pete) Stark (chairman of the subcommittee) presiding.

[The press release announcing the hearing and a copy of the bill, H.R. 4742, follow:]

FOR IMMEDIATE RELEASE
TUESDAY, JUNE 3, 1986

PR #11
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D. C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE FORTNEY H. (PETE) STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES A HEARING ON THE HEALTH CARE IMPROVED ACCESS ACT OF 1986, H.R. 4742, TO BE HELD MONDAY, JUNE 9, 1986

The Honorable Fortney H. (Pete) Stark (D., Calif.), Chairman of the Subcommittee on Health, Committee on Ways and Means, U. S. House of Representatives, today announced that the Subcommittee on Health will hold a hearing on legislation that addresses the issue of more fairly providing access to health care. The hearing, which will focus on "The Health Care Improved Access Act of 1986" (H.R. 4742), will begin at 1:00 p.m. on Monday, June 9, 1986, in room B-318 Rayburn House Office Building.

More than 12 percent of Americans - 28 million people - appear to have particularly serious trouble coping with the health care system and obtaining care when they need it, according to a University of Chicago study. These 21 million adults and seven million children (1) do not have health insurance; (2) do not have a regular source of medical care because of their financial problems; and (3) put off care or were unable to find it in the previous 12 months. The most recent Census Bureau statistics provide an even more negative picture. Thirty-seven million Americans - one out of every six citizens - have no health insurance. Since 1980, the number of persons without such coverage has soared by 42 percent.

At the same time as the number of Americans without health insurance is increasing, hospitals are facing a growing burden in providing care for the seriously ill who cannot pay. Between 1980 and 1984, the cost of hospital charity care doubled from $2.8 billion to $5.7 billion.

Chairman Stark and Congressman Bill Gradison (R., Ohio) address these concerns in their bill, the Health Care Improved Access Act of 1986, H.R. 4742, which would:

-- Extend employment-based health insurance coverage for laid-off workers and their dependents for up to four months;

-MORE-

-- Create subsidized health insurance pools to allow people without employment-based coverage to buy health insurance regardless of their health status;

-- Require that states establish a mechanism to fund hospital charity care or develop a plan to provide health insurance to all uninsured residents;

-- Provide a more equitable tax treatment to encourage self-employed individuals to offer health insurance to employees; and

-- Develop methods to lower the cost of health insurance to small businesses.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearing, six copies are required and must be submitted by the close of business on Monday, June 23, 1986, to Joseph K. Dowley, Chief Counsel, Committee on Ways and Means, U. S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

SEE ENCLOSED FORMATTING REQUIREMENTS

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I

99TH CONGRESS
2D SESSION

H. R. 4742

To amend the Internal Revenue Code of 1954 to assure access to health insurance, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 1, 1986

Mr. STARK (for himself and Mr. GRADISON) introduced the following bill; which was referred to the Committee on Ways and Means

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A BILL

To amend the Internal Revenue Code of 1954 to assure access to health insurance, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Health Care Improved Access Act of 1986".

TABLE OF CONTENTS

Sec. 1. Short title.
Sec. 2. Incentives for the establishment of statewide insurance pools.
Sec. 3. Requiring State plans for payment for uncompensated and charity inpatient and outpatient hospital care.
Sec. 4. Temporary extension of coverage for laid-off workers; open enrollment for spouses of unemployed workers.
Sec. 5. Deduction allowable for certain group health plan contributions by self-employed individuals.
Sec. 6. Demonstration projects on improving access to health insurance for small employers and self-employed individuals.

SEC. 2. INCENTIVES FOR THE ESTABLISHMENT OF STATEWIDE INSURANCE POOLS.

(a) General Rule.—Chapter 41 of the Internal Revenue Code of 1954 is amended by adding at the end thereof the following new subchapter:

"Subchapter B—Health Plans of Large Employers Not Members of Qualified State Pooling Associations

"Sec. 4912. Tax on expenses of health plans of large employers not members of qualified State pooling associations.

"SEC. 4912. TAX ON EXPENSES OF HEALTH PLANS OF LARGE EMPLOYERS NOT MEMBERS OF QUALIFIED STATE POOLING ASSOCIATIONS.

"(a) Tax Imposed.—In the case of a large employer, there is hereby imposed a tax equal to 10 percent of the amount of the nonqualified employee health expenses paid or incurred during the taxable year.

"(b) Large Employer.—For purposes of this section—

"(1) In general.—Except as provided in paragraph (2), the term 'large employer' means an employer who, on each of some 20 days during the taxable year or the preceding taxable year, each day being in a different calendar week, employed for some portion of the day (whether or not at the same moment of time) 20 or more individuals.

"(2) EXCEPTION FOR GOVERNMENTAL UNITS.—The term 'large employer' shall not include the United States, any State or political subdivision thereof, or any possession of the United States or any agency or instrumentality of any of the foregoing (including the United States Postal Service and Postal Rate Commission); except that such term shall include any nonappropriated fund instrumentality of the United States.

"(c) NONQUALIFIED EMPLOYEE HEALTH EXPENSES.—For purposes of this section—

"(1) IN GENERAL.—The term 'nonqualified employee health expenses' means the expenses paid or incurred by the employer for a group health plan to the extent such expenses are allocable—

"(A) to employment within a State, and

"(B) to a period during which neither

"(i) the employer, nor

"(ii) any entity through which benefits under the plan are provided,

is a member of a qualified pooling association in such State.

"(2) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given to such term by section 162(i)(3).

"(3) QUALIFIED POOLING ASSOCIATION.—The term 'qualified pooling association' means any organization which—

"(A) is a nonprofit corporation established pursuant to and regulated by State law;

"(B) permits any of the following doing business in the State to be participating members:

"(i) insurers writing expense incurred health insurance,

"(ii) hospital and medical service plan corporations,

"(iii) health maintenance organizations, and

"(iv) employers and other health financing entities (including self-funding entities and employee welfare benefit plans);

"(C) makes available (without regard to health conditions) to all residents of the State, who are not eligible for medicare, levels of health insurance typical of the levels of coverage provided through large employer groups, except that—

"(i) any such level of insurance must limit the amount of the annual out-of-pocket expenses for covered services under individual coverage to $1,500 and under family coverage to $3,000,

"(ii) any such level of insurance may not establish a lifetime benefit limit for any individual of less than $500,000,

"(iii) subject to clause (i), such insurance may provide for a choice of deductibles (in addition to the deductibles typical of levels of coverage provided through large employer groups), but not to exceed $1,000 for each covered individual, and

"(iv) such insurance may deny coverage for covered services for preexisting conditions for a period not to exceed 6 months;

"(D) charges a pool premium rate expected to be self-supporting based upon a reasonable actuarial determination of anticipated experience and expected expenses, such pool premium rate in no event to exceed 150 percent of average premium rates for individual standard risks in the State for comparable coverage; and

"(E) assesses losses of the pool equitably among all participating members.

Nothing in this paragraph shall be construed as preventing a State or other entity from providing for payment of part or all of the premium of an enrollee and from varying the amount of such payment based on the enrollee's income or other basis.

"(4) MEDICARE.—The term 'medicare' means the insurance program established under part A of title XVIII of the Social Security Act.

"(d) CROSS REFERENCE.—

"(1) For provision denying deduction for tax imposed by this section, see section 275(a)(6).

"(2) For provisions making deficiency procedures applicable to tax imposed by this section, see section 6211 et seq."

(b) CLERICAL AMENDMENTS.—

(1) Chapter 41 of such Code is amended by striking the chapter heading and inserting the following:

"CHAPTER 41—PUBLIC CHARITIES; CERTAIN HEALTH PLANS OF LARGE EMPLOYERS

"Subchapter A. Public charities.
"Subchapter B. Health plans of large employers not members of qualified State pooling associations.

"Subchapter A—Public Charities".

(2) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 41 and inserting the following:

"Chapter 41. Public charities; certain health plans of large employers."

(3) Subparagraph (B) of section 6104(c)(1) of such Code is amended by striking "or chapter 41 or 42" and inserting ", subchapter A of chapter 41 or chapter 42".

(c) Effective Date.—

(1) In general.—The amendments made by this section shall apply to taxable years beginning on or after January 1, 1988.

(2) Exception for taxpayers located in certain states.—

(A) In general.—In the case of a taxpayer located in a State in which the first regular State legislative session does not end before January 1, 1988, the amendments made by this section shall apply to taxable years of the taxpayer beginning on or after the first January 1st that occurs after the close of the first regular State legislative session of the State.

(B) First regular state legislative session defined.—In subparagraph (A), the 'first regular State legislative session' refers to the first regular session of a State legislature that begins after the date of the enactment of this Act.

SEC. 3. REQUIRING STATE PLANS FOR PAYMENT FOR UNCOMPENSATED AND CHARITY INPATIENT AND OUTPATIENT HOSPITAL CARE.

(a) Medicare Condition of Participation.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)), as amended by sections 9121(a), 9122(a), and

9403(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended—

(1) by striking "and" at the end of the subparagraph (I) inserted by section 9121(a) of such Act,

(2) by striking the period at the end of subparagraph (J) and inserting a comma,

(3) by redesignating the subparagraph (I) inserted by section 9403(b) of such Act as subparagraph (K) and by inserting it after subparagraph (J), and

(3) by inserting after subparagraph (J), as so redesignated, the following new subparagraph:

"(L) in the case of hospitals which provide inpatient or outpatient hospital services for which payment may be made under this title, to be located in a State that the Secretary determines—

"(i) has in effect a qualified State plan of assistance for the uninsured and underinsured that meets the requirements of section 1819, or

"(ii) provides for health care coverage—

"(I) that may be a health maintenance organization or other management system of care, and

"(II) that pays for the costs of (or provides) inpatient and outpatient hospital services in the State, for all individuals in the State who (but for this clause) would qualify to have payments for such services made under a plan described in clause (i).".

(b) REQUIREMENTS FOR QUALIFIED STATE PLANS OF ASSISTANCE FOR THE UNINSURED AND UNDERINSURED.—Part A of title XVIII of such Act is amended by adding at the end the following new section:

"REQUIREMENTS FOR QUALIFIED STATE PLANS OF ASSISTANCE FOR THE UNINSURED AND UNDERINSURED

"SEC. 1819. (a) The requirements, referred to in section 1866(a)(1)(L)(i), for a qualified State plan of assistance for the uninsured and underinsured are as follows:

"(1)(A) The plan must provide for payment for the unreimbursed costs incurred by each hospital in the State in furnishing medically necessary inpatient and outpatient services. Such unreimbursed costs may be determined on a patient by patient basis, on the basis of a prospectively approved budget for a hospital, on the basis of costs that are reasonable and necessary for the provision of services, or on another reasonable basis established by the State.

"(B) Payment may not be made under the plan for costs—

"(i) respecting care provided by a hospital pursuant to an assurance under title VI or XVI of the Public Health Service Act (commonly known as the Hill-Burton program) that the hospital will make available a reasonable volume of services to persons unable to pay therefor,

"(ii) respecting obligations to pay taxes,

"(iii) for which charges can reasonably be expected to be collected with suitable bill collection mechanisms,

"(iv) for care for which payment is made under this title, or

"(v) for care for which payment is made under a State plan approved under title XIX.

"(2) The plan must have adequate financing through a mechanism established by the State.

"(3) The plan must not provide for a legal or regulatory limit on the amount of charity and unreimbursed care a hospital may provide.

"(b) Notwithstanding subsection (a), a plan may—

"(1) provide that no payment will be made under the plan for any unpaid deductible or coinsurance amount not in excess of $250;

"(2) take into account, and require continuation of, the payment, from State and local taxes, of amounts for charity and unreimbursed care at the levels in effect during fiscal year 1985 (with such adjustments to take into account changes in prices, costs, tax collections, or other reasonable items as the plan may provide), and

"(3) require, as a condition of payment under the plan to a hospital, that the hospital (A) provide a certain level of charity and unreimbursed care for inpatient and outpatient hospital services, and (B) meet minimum standards in its efforts to collect unpaid bills."

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall apply to agreements entered into or renewed under section 1866 of the Social Security Act on or after January 1, 1988.

(2) EXCEPTION FOR HOSPITALS LOCATED IN CERTAIN STATES.—

(A) IN GENERAL.—In the case of a hospital located in a State in which the first regular State legislative session does not end before January 1, 1988, the amendment made by subsection (a) shall apply to agreements as of the first January 1st that occurs after the close of the first regular State legislative session of the State.

(B) FIRST REGULAR STATE LEGISLATIVE SESSION DEFINED.—In subparagraph (A), the "first regular State legislative session" refers to the first regular session of a State legislature that begins after the date of the enactment of this Act.

SEC. 4. TEMPORARY EXTENSION OF COVERAGE FOR LAID-OFF WORKERS; OPEN ENROLLMENT FOR SPOUSES OF UNEMPLOYED WORKERS.

(a) DENIAL OF DEDUCTION FOR EMPLOYER CONTRIBUTION TO PLAN.—Paragraph (2) of section 162(i) of the Internal Revenue Code of 1954 (relating to deduction for trade or business expenses with respect to group health plans), as amended by section 10001(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended—

(1) in the heading, by inserting "AND OPEN ENROLLMENT OPTION FOR SPOUSES OF UNEMPLOYED WORKERS" after "CERTAIN INDIVIDUALS", and

(2) in subparagraph (A), by inserting "and the spousal open enrollment requirements of subsection (l)" after "subsection (k)".

(b) DENIAL OF EXCLUSION FOR HIGHLY COMPENSATED INDIVIDUALS.—Section 106(b) of such Code (relating to contributions by employer to accident and health plans), as amended by section 10001(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended—

(1) in paragraph (1), by striking "meet" and all that follows to the end of the paragraph and inserting the following: "meet—

"(A) the continuing coverage requirements of section 162(k), and

"(B) the spousal open enrollment requirements of section 162(l).",

(2) by striking "Paragraph (1)" in paragraph (2) and inserting "Paragraph (1)(A)", and

(3) by amending subparagraph (B) of paragraph (2) to read as follows:

"(B) a plan established and maintained for its employees by the Government of the United States, or by any agency or instrumentality of such, and a plan described in the second sentence of section 414(d), or".

(c) MODIFICATION OF CONTINUATION COVERAGE REQUIREMENTS.—

(1) EXTENSION OF CONTINUATION PERIOD.—Paragraph (2)(B)(i)(I) of section 162(k) of such Code (relating to maximum period of continuation coverage), as inserted by section 10001(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by striking "18 months" and inserting "22 months".

(2) CLARIFICATION OF RIGHT TO TERMINATE CONTINUATION COVERAGE.—Paragraph (2)(B) of such section (relating to period of continuation coverage) is amended by adding at the end the following clause:

"(vi) NOTICE OF TERMINATION OF COVERAGE.—The date on which the qualified beneficiary notifies the plan administrator, in writing, that the coverage should be terminated."

(3) EMPLOYER CONTINUATION OF PREMIUM PAYMENTS FOR 4 MONTHS.—

(A) IN GENERAL.—Paragraph (2) of such section (relating to continuation coverage) is further amended by adding at the end the following new subparagraph:

"(F) SPECIAL RULES FOR CERTAIN QUALIFIED BENEFICIARIES.—

"(i) IN GENERAL.—In the case of a qualifying event described in paragraph (3)(B) (relating to terminations and reduced hours), during the period described in clause (ii)—

"(I) the amount and frequency of payment of any premium charged under subparagraph (C) shall be under the same terms and conditions as if the qualifying event had not occurred, and

"(II) subparagraph (B)(iii) shall only apply to failures of the qualified beneficiary to pay the premium required with respect to the beneficiary.

"(ii) PERIOD OF APPLICATION.—The period described in this clause is the period beginning on the day after the date of the qualifying event and ending at the end of—

"(I) 4 months, or

"(II) the number of months (before the date of the qualifying event) for which the qualified beneficiary was provided coverage under the group health plan,

whichever is less."

(B) PROMPT ELECTION REQUIRED.—Paragraph (5) of such section (relating to the election of continuation coverage) is amended by adding at the end the following new subparagraph:

"(C) SPECIAL RULES FOR CERTAIN ELECTIONS.—In the case of an election respecting a qualifying event described in paragraph (3)(B) (relating to terminations and reduced hours), in order to obtain the benefits of paragraph (2)(F), the qualified beneficiary must make the election during the first 14 days of the election period.".

(4) NOTICE OF REQUIREMENTS.—Paragraph (6) of such section (relating to notice requirements) is amended—

(A) in subparagraph (A), by inserting "and subsection (l)" after "this subsection",

(B) in subparagraph (B), by inserting "(or 7 days in the case of a qualifying event described in paragraph (3)(B))",

(C) in the second sentence, by striking "within 14 days of the date on which the plan administrator is notified under subparagraph (B) or (C)" and inserting "within 7 days of the date on which the plan administrator is notified under subparagraph (B) or within 14 days of the date on which the plan administrator is notified under subparagraph (C)", and

(D) by adding at the end the following: "Each notice under subparagraph (D)(i), in the case of a qualifying event described in paragraph (3)(B), shall include information concerning the special rules in paragraphs (2)(F) and (5)(C)."

(d) SPOUSAL OPEN ENROLLMENT REQUIREMENT.—Section 162 of such Code is further amended by redesignating subsection (l) as subsection (m) and by inserting after subsection (k) the following new subsection:

"(l) SPOUSAL OPEN ENROLLMENT REQUIREMENTS OF GROUP HEALTH PLANS.—

"(1) IN GENERAL.—For purposes of subsection (i)(2) and section 106(b)(1), a group health plan meets the requirements of this subsection only if the plan provides for an open enrollment period (meeting the requirements of this subsection) for each married employee—

"(A) who is (or, but for a previous election, would be) covered under the plan, and

"(B) whose spouse loses or will lose coverage under a group health plan due to a qualifying event (described in subsection (k)(3)(B)).

"(2) OPEN ENROLLMENT PERIOD.—The open enrollment period must—

"(A) be a period of not less than 60 days, and

"(B) begin not earlier than 30 days before the date of the qualifying event and not later than such date, except, at the option of the employee, the period may be delayed to begin on a date not later than the date the employee's spouse actually loses coverage under a group health plan.

"(3) LOSS OF COVERAGE.—For purposes of this subsection, a spouse shall not be considered to have lost coverage during any period (after a separation from employment) in which the coverage is continued and for which a contribution toward the cost of the coverage is being made by an employer, union, or entity other than the spouse.

"(4) TERMS OF ENROLLMENT OPTION.—

"(A) NO REQUIREMENT OF INSURABILITY.—The terms of such an enrollment may not require, or discriminate on the basis of lack of, evidence of insurability.

"(B) BENEFITS AND ENROLLMENT.—Except as provided in subparagraph (C), the coverage and terms of an enrollment during an open enrollment period provided under this subsection shall be the same as the terms (including any option for coverage of immediate family members) most recently offered with respect to the enrollment of that employee or (at the employer's option) of newly hired or other employees similarly situated.

"(C) EFFECTIVE DATE OF COVERAGE.—Except as provided in subparagraph (D), the coverage provided pursuant to an individual's enrollment during an open enrollment period under this subsection shall be effective no later than—

"(i) the first day of the first pay period that begins more than 5 days after the date the individual enrolls, or

"(ii) 30 days after the date the individual enrolls,

whichever is earlier.

"(D) IMMEDIATE COVERAGE OF ADDED FAMILY MEMBERS.—If an employee was previously covered and only exercises the option to cover immediate family members, the coverage of the immediate family members shall begin not later than the first day of the first pay period that begins after the date the individual exercises the option.".

(e) EFFECTIVE DATES.—

(1) GENERAL RULE.—The amendments made by this section shall apply to plan years beginning on or after January 1, 1987.

(2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and

one or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the earlier of—

(A) the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act), or

(B) July 1, 1987.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this section shall not be treated as a termination of such collective bargaining agreement.

(f) Notification to Covered Employees.—At the time that the amendments made by this section apply to a group health plan described in section 162(i) of the Internal Revenue Code of 1954, the plan shall notify each covered employee, and spouse of the employee (if any), who is covered under the plan at that time of the continuation coverage and open enrollment period required sections 162(k) and 162(l) of such Code. The notice furnished under this subsection is in lieu of notice that may otherwise be required under section 162(k)(6)(A) of such Code.

SEC. 5. DEDUCTION ALLOWABLE FOR CERTAIN GROUP HEALTH PLAN CONTRIBUTIONS BY SELF-EMPLOYED INDIVIDUALS.

(a) IN GENERAL.—Section 162 of the Internal Revenue Code of 1954 (relating to trade or business expenses), as amended by section 4 of this Act, is further amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following new subsection:

"(m) DEDUCTION ALLOWABLE FOR CERTAIN GROUP HEALTH PLAN CONTRIBUTIONS FOR THE BENEFIT OF SELF-EMPLOYED INDIVIDUALS.—

"(1) IN GENERAL.—For purposes of this section and sections 212, 104, 105, and 106, in the case of a qualified group health plan which provides medical care benefits for any self-employed individual—

"(A) such individual shall be treated as an employee,

"(B) the employer of such individual shall be treated as being the person so treated under section 401(c)(4), and

"(C) contributions to such plan for medical benefits for such individual shall be treated as meeting the requirements of subsection (a) and section 212 to the extent such contributions during the taxable year do not exceed the lowest per/employee contribution to the plan made by the employer during such year.

"(2) DEDUCTION CANNOT EXCEED TAXABLE INCOME FROM ACTIVITY.—The deduction allowed to any individual by reason of this subsection for any taxable year shall not exceed the portion of the taxable income of such individual (determined without regard to this subsection) for such year which is allocable or apportionable to such individual's interest in the employer.

"(3) QUALIFIED GROUP HEALTH PLAN.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'qualified group health plan' means, with respect to any self-employed individual, any group health plan (as defined in subsection (i)(2)) of an employer if—

"(i) such plan is not a self-insured plan, and

"(ii) such plan meets the requirements of subparagraphs (B) and (C).

"(B) ONE-HALF OF PARTICIPANTS MUST BE EMPLOYEES WHO ARE NOT SELF-EMPLOYED IN-

DIVIDUALS OR EMPLOYEE FAMILY MEMBERS OF SUCH INDIVIDUALS.—

"(i) IN GENERAL.—A plan meets the requirements of this subparagraph with respect to any self-employed individual only if at least half of the participants in the plan (on each day of the taxable year of such individual) are employees who are not—

"(I) self-employed individuals to whom a deduction is allowable by reason of this subsection with respect to contributions to such plan, or

"(II) family members of any self-employed individual described in subclause (I).

"(ii) FAMILY MEMBER.—For purposes of clause (i), the term 'family member' means, with respect to an individual, such individual's brothers and sisters (whether by the whole or half blood), spouse, ancestors, and lineal descendants.

"(C) PLAN MUST BENEFIT ALL EMPLOYEES (OTHER THAN PART-TIME AND SEASONAL EMPLOYEES) NOT COVERED BY ANOTHER GROUP HEALTH PLAN.—A plan meets the requirements of this subparagraph only if such plan benefits all employees (other than part-time and seasonal employees) of the employer who do not benefit under a group health plan of an unrelated employer.

"(D) Self-insured plan.—The term 'self-insured plan' means any plan under which medical care benefits are not provided under a policy of accident and health insurance.

"(4) Lowest per/employee contribution.—

"(A) In general.—For purposes of this subsection, the term 'lowest per/employee contribution' means, with respect to any taxable year of a self-employed individual, the smallest contribution made by the employer during such taxable year to the plan with respect to any employee—

"(i) who is not a self-employed individual,

"(ii) with respect to whom a contribution to the plan was made during such year, and

"(iii) who is in the same category of coverage as the self-employed individual.

"(B) Categories of coverage.—For purposes of subparagraph (A), the categories of coverage are—

"(i) self only, and

"(ii) self and family.

"(C) SELF-EMPLOYED INDIVIDUALS WHO ARE PARTICIPANTS FOR LESS THAN ENTIRE TAXABLE YEAR.—In the case of a self-employed individual who is a participant in the plan for less than the entire taxable year, the lowest per/employee contribution applicable to such individual shall be the same portion of amount determined under subparagraph (A) as the portion of the taxable year during which such individual was a participant in the plan bears to the entire taxable year.

"(D) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) only contributions for coverage during the taxable year shall be taken into account, and

"(ii) the contributions with respect to any employee who is not a participant in the plan for the entire taxable year shall be determined on an annualized basis.

"(5) OTHER DEFINITIONS.—For purposes of this subsection—

"(A) SELF-EMPLOYED INDIVIDUAL.—The term 'self-employed individual' has the meaning given such term by section 401(c)(1)(B).

"(B) MEDICAL CARE BENEFITS.—The term 'medical care benefits' means, with respect to any self-employed individual, compensation for the medical care (as defined in section 213(d)) of such individual, the spouse of such individual, and dependents of such individual.

"(C) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152. Any child to whom section 152(e) applies shall be treated as a dependent of both parents.

"(6) SPECIAL RULES.—

"(A) COORDINATION WITH SECTION 213.—Any amount allowed as a deduction by reason of this subsection shall not be treated as an amount paid for medical care under section 213.

"(B) AGGREGATION OF EMPLOYER PLANS.—If any self-employed individual is a participant in 2 or more qualified group health plans of the employer, all such plans shall be treated as 1 plan for purposes of this subsection."

(b) TECHNICAL AMENDMENT.—Subsection (g) of section 105 of such Code (relating to self-employed individual not considered an employee) is amended by striking out "For purposes of this section" and inserting in lieu thereof "Except as provided in section 162(m)(1), for purposes of this section".

(c) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 1986.

SEC. 6. DEMONSTRATION PROJECTS ON IMPROVING ACCESS TO HEALTH INSURANCE FOR SMALL EMPLOYERS AND SELF-EMPLOYED INDIVIDUALS.

(a) Studies and Demonstration Projects.—The Secretary of Health and Human Services shall provide for the conduct of studies and demonstration projects on ways to reduce the costs for small employers and self-employed individuals in obtaining health insurance. In particular the Secretary shall examine, demonstrate, and evaluate how savings in marketing and administrative costs can be achieved through the use of—

(1) standardized policy packages,

(2) State arrangements for the pooling of health insurance,

(3) State or Federal reinsurance of group health contracts,

(4) contracts with banks to offer such insurance to depositors or other groups,

(5) contracts with medicare carriers,

(6) contracts or grants to Chambers of Commerce or similar groups representing business, and

(7) other innovative means.

(b) REPORT.—The Secretary shall report to Congress on the results of the studies and demonstration projects not later than January 1, 1988.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each fiscal year (beginning with fiscal year 1987) such sums as may be appropriate to carry out this section.

Chairman **Stark**. The Subcommittee on Health will proceed.

I apologize to the audience. If staff can provide more chairs, maybe more people can sit down.

I want to apologize for my colleagues on both sides of the aisle. We scheduled these hearings, and the time limitation pushed us to do it on Monday. Many members have indicated that they are sorry to miss the hearing today. It is an important hearing, since the financial obstacles to medical care confront too many of our citizens.

The number of Americans without health insurance has grown in just 5 short years from 25 million to 37 million. This is equal to the total population of half of the States in this country. While many of the uninsured have been receiving medical care by one means or another, this care is not evenly distributed nor is it readily available to all those in need.

Hospitals and clinics once got away with padding other patients' bills to raise the now $6 billion a year it costs to care for the uninsured. Federal, State, and private insurance plans are tightening up on reimbursements and eliminating this hidden subsidy. As a result, according to a recent study conducted by the Robert Wood Johnson Foundation, a million people in 1983 were refused medical treatment. Another 4 million families reported that they or someone in their families needed medical care but did not obtain it. All indications are that this situation is worsening.

Equity, fairness, and good sense call for Federal initiatives to assure that all Americans will have access to medical care. But there are no magic bullets. The Improved Access to Health Care Act of 1986, H.R. 4742, introduced by Congressman Gradison and myself, takes positive, careful steps to promote greater access to care in four specific ways.

First, it requires employers to continue for up to 4 months health insurance for the estimated 10 million workers and their families, who are laid off each year.

Second, this bill requires States to establish pools so that all residents have an opportunity to purchase comprehensive health insurance, regardless of their health status.

Third, it requires States to establish programs to finance essential health care for those who cannot pay.

Fourth, the legislation creates an incentive for unincorporated owners to provide health insurance for themselves and their employees.

It is a tragedy that a nation with the finest of medical care systems has not found a way to assure access to medical care for all its citizens. This indigent care issue has been called a uniquely American tragedy.

What we are proposing in H.R. 4742 are affordable and achievable goals. While it doesn't close all of the gaps, it takes a vital step in that process and keeps us moving in the right direction. I hope the witnesses today will help us flesh out these proposals so that they may serve their intended purposes of improving access to medical care.

[The statement of Chairman Stark follows:]

OPENING STATEMENT OF CONGRESSMAN FORTNEY H. (PETE) STARK

Financial obstacles to medical care confront too many of our citizens. The number of Americans without health insurance has grown in just 5 short years from 25 to 37 million. This is equal to the total population of half of the States in this country. While many of the uninsured have been receiving medical care by one means or another, this care is not evenly distributed nor is it readily available to all those in need.

Hospitals and clinics once got away with padding other patients' bills to raise the now $6 billion a year it costs to care for the uninsured. Federal, State, and private insurance plans are tightening up on reimbursements and eliminating this hidden subsidy. As a result, according to a recent study by the Robert Wood Johnson Foundation, 1 million people in 1983 were refused medical treatment. Another 4 million families reported that they or someone in their families needed medical care but did not obtain it. All indications are that this situation is worsening.

Equity, fairness and good sense call for Federal initiatives to assure that all Americans will have access to medical care. But there are no magic bullets. The "Improved Access to Health Care Act of 1986," H.R. 4742, introduced by Congressman Gradison and myself, takes positive, careful steps to promote greater access to care in four specific ways.

First, it requires employers to continue for up to 4 months health insurance for the estimated 10 million workers and their families, who are laid off each year. Just as the unemployment insurance system has protected Americans against loss of income, our proposal would guarantee the unemployed health insurance protection. This benefit would solve the problem for a majority of the unemployed as 70 percent are rehired within 4 months. The Congressional Budget Office estimates that the maximum cost to employers would be $1.5 billion a year, less than seven-hundredths of 1 percent of current payroll.

Second, this bill requires States to establish pools so that all residents have an opportunity to purchase comprehensive health insurance, regardless of their health status. Some 2 million Americans will benefit if the 41 States that don't now have risk pools establish them. Almost all States have mechanisms to provide auto insurance for otherwise uninsurable motorists. The handicapped and those with chronic diseases deserve help at least as generous in obtaining the coverage they need.

Third, it requires States to establish programs to finance essential health care for those who cannot pay. For decades, the cost of care for those unable to pay has been financed out of earnings from paying patients. Cost containment and competition have reduced the ability of hospitals to subsidize this care, which has jumped from $2.8 billion in 1980 to $5.7 billion in 1984. Enactment of this proposal will assure that patients with serious illnesses can obtain the care they need.

Fourth, the legislation creates an incentive for unincorporated owners to provide health insurance for themselves and their employees. Unincorporated owners face a significant tax disincentive in providing health insurance because under current law they can't deduct the cost of their own health insurance as a business expense. Fully three-quarters of those without health insurance are workers or dependents of workers-and three quarters of these in turn work for small businesses. Our proposal encourages these owners to provide health insurance by enabling them to deduct the cost of their own personal insurance as business expense only if they provide comparable coverage for their workers.

It is a tragedy that a nation with the finest of medical care systems has not found a way to assure access to medical care for all its citizens. This indigent care issue has been called a "Uniquely American Tragedy."

What we are proposing in H.R. 4742 are affordable and achievable goals. While it doesn't close all of the gaps it takes a vital step in that process and keeps us moving in the right direction. I hope the witnesses today will help us flesh out these proposals so that they may serve their intended purposes of improving access to medical care.

Chairman **STARK**. I am going to hold quite carefully to having each participant limit their testimony to 5 minutes. I ask each witness to please summarize their written testimony, which I assure you will be studied thoroughly by the staff and the members of this committee. Without fear of objection today, I will tell you all that any written material and your complete statements will appear in the record in their entirety. I will keep the record open and ask the witnesses to be willing to respond in writing to questions that members may submit to them in the next week or so.

Having said that, we will proceed with the first panel and welcome Bert Seidman of the American Federation of Labor, Jack Owen of the American Hospital Association, and Willis Goldbeck, the president of the Washington Business Group on Health, who will deal with an overview of the access problem.

If you have decided in what order you want to proceed, you may proceed in any manner you want. I will let you be self-enforcing. We will go 15 or 20 minutes, and then see how much more we want to talk.

Who is going to lead off?

Bert, you are listed at the head of the list. Go ahead.

I am sorry. Mr. Coyne, did you have a statement?

Mr. COYNE. No.

Chairman STARK. Thank you for joining us.

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF OCCUPATIONAL SAFETY, HEALTH AND SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR & CONGRESS OF INDUSTRIAL ORGANIZATIONS, ACCOMPANIED BY CAL JOHNSON, LEGISLATIVE DEPARTMENT

[The prepared statement begins at p. 40.]

Mr. SEIDMAN. I am Bert Seidman, director of the Department of Occupational Safety, Health and Social Security of the AFL-CIO.

With me is Cal Johnson, a member of the legislative department of the AFL-CIO.

The AFL-CIO is pleased to present testimony today in support of H.R. 4742, the Improved Access to Health Care Initiative. We were one of the organizations present when the press conference was held announcing the bill, and welcome the initiative of you and your colleagues who have cosponsored the bill.

We, in organized labor, share the committee's concern about the dramatic growth over the past 5 years in the number of citizens without health insurance protection and, thus, without regular access to the health care delivery system. A less obvious problem, but with equally serious ramifications for policymakers, is the shocking jump in the number of individuals who are judged to have inadequate health insurance coverage. There are all sorts of figures as to the numbers of people without health care coverage and the numbers who are with inadequate health care coverage.

We were interested that a recent study by the Washington, DC, Government Research Corp., a private organization, estimated the population with inadequate health care coverage to be as large as 50 million. Adding this to the 35 million known to be without any health care protection—of these, two-thirds are in the work force, or their dependents—the number could be as large as 85 million who do not have adequate access to health care services.

The AFL-CIO strongly believes that the best medicine for this problem would be the enactment of a national health care system, which makes access to basic health care services a right for all Americans. Lacking such a system, individuals with chronic health care problems are locked out of the system because they cannot obtain insurance protection, and health care coverage is denied to people when they lose their jobs or any other source of income. If they lose their Medicaid coverage or if they lose their disability insurance coverage under Social Security, they also lose their health care coverage.

The problem of the uninsured and underinsured has escalated as a result of a confluence of public and private sector developments. There have been cutbacks in public programs to the point where Medicaid now covers less than 50 percent of those living under the poverty line. Because of excessive increases in the cost of insurance, purchasers in the private sector have become more price-sensitive and increasingly unwilling to subsidize the cost of care to the uninsured. That cost amounts to $6 billion nationally and threatens the very existence of public hospitals and other providers of last resort for those without coverage or with inadequate protection.

So, we commend you and the other sponsors of H.R. 4742 which would provide health care for those currently uncovered. We have a number of concerns about the bill, and I will state them briefly.

First, H.R. 4742 will address the short-term health care needs of the unemployed who, when laid off, not only experience the trauma of joblessness but also lose their link to the health care system. The requirement that employers continue coverage for 4 months after layoff is a positive step, but it does not address the needs of the 25 percent of the unemployed who have been jobless for more than 4 months. So, we are concerned about the long-term unemployed who will not be covered by the limited extension in the bill.

Second, we are concerned that absent any targeting requirements in the bill for State insurance pools, public hospitals and other facilities serving a disproportionate share of patients without insurance protection may not receive their fair share of funds.

Third, we believe that a provision specifying what constitutes bad debt and charity care should be added to the bill to bar facilities from shifting the costs of such discounts on to State uncompensated care pools.

Fourth, we believe that somewhere in the bill there should be a definition of bad debt and charity care and the term "underinsured."

Fifth, if Congress intends to allow States to deal with the uninsured and underinsured problem by allowing them to set up a managed system of care, then it should specify what it means by managed care in addition to requiring some basic quality controls to protect the health of potential participants.

With respect to the issue of requiring employers to contribute to a State pool for individuals who cannot obtain insurance protection because they are chronically ill or at high risk of becoming ill, the AFL-CIO supports the principle underlying this provision: That there should be an equitable risk-sharing arrangement to distribute the cost of care for victims of chronic diseases.

On the other hand, although the bill sets a maximum on premiums that can be charged to such individuals participating in State risk pools, this cap will no doubt become the only rate, leaving us with serious concerns about the potential pool of eligibles who will not be able to afford such coverage.

Because the premium and out-of-pocket maximums, which are also certain to become the exclusive amounts, may be affordable only to families with relatively high incomes, in the interest of equity we believe the committee should consider instructing States to establish a sliding scale based on income for premium requirements as well as out-of-pocket payments. Currently, the bill would merely not prohibit a State from doing so.

In addition, it should be clearly spelled out in the bill that a State may not charge higher rates to those individuals with relatively poor medical histories.

Before concluding our statement, Mr. Chairman, the AFL-CIO would like to inform the committee that we have been working with a group of our affiliated unions and consumer organizations to develop a model initiative of our own to address the needs of the uninsured and underinsured. Our model, which will be available shortly, has a Federal and State component.

Like H.R. 4742, it would offer States various options for improving access to care. However, we recommend requiring States to establish a public commission, with a majority of its members, health care consumers, to implement such a plan. It would also require that hospitals with the greatest need be targeted for relief from expenditures for bad debt and charity care, and it would set out general guidelines for case management systems.

We are also preparing a model State bill that would take the next step and implement the Federal guidelines. These are all in the process of preparation.

We commend the subcommittee for taking the initiative in attempting to improve access to health care services for the underinsured and uninsured, and are prepared to work closely with you to pass this important initiative.

Thank you.

Chairman **Stark**. Mr. Owen.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

[The prepared statement begins at p. 42.]

Mr. **Owen**. I am Jack Owen, executive vice president of the American Hospital Association. The highest priority for our association is finding a solution to the growing crisis of medical indigence and taking care of the uncompensated care problem. We applaud you for your efforts, and the committee's efforts, to approach this problem because it is a problem.

In February 1986, the board, the American Hospital Association Special Committee on Care of the Indigent, completed its report. Interestingly enough, many of their recommendations are contained in your bill. For instance, one of the recommendations would be to increase the number of insured; two, requiring States to establish uncompensated care plans; three, extending the continuation coverage period of laid-off workers; four, permitting self-employed owners of small businesses to take as a business deduction the cost of their individual family insurance; and, five, authorizing demonstration projects on improving access to health insurance.

I will not repeat what we approve in the bill, but only cover those positions in which we feel some amendments might be helpful. One of the major disadvantages that we see in this bill would place the burden on already insured firms without taxing uninsured firms. To the extent that State plans include subsidized premiums, the result would be that companies that insure employees could be subsidizing those that do not and insurers could be subsidizing a product that competes with their own. This could tempt some firms to drop their insurance coverage and some private insurers to back away from the individual and small group market.

A related problem in the bill would exempt Federal, State, and local government from the pooling requirement which would increase the burden for insured employees. If you leave those out, that means less of a pool.

The third problem is that employers and States who fail to set up a risk pool and employers who operate out of a risk pool membership would be taxed, yet the tax money would not necessarily be targeted for the medically indigent.

The fourth problem is employees would not be able to determine in advance what their assessment to cover losses would be so they might be tempted to avoid the risk of paying a 10-percent tax, an outcome that would be particularly unfortunate if the tax revenues are not earmarked for health care.

With regard to the charity side of it, the plan would not establish a legal or regulatory limit on the amount of charity unreimbursed care a hospital may provide, nor does the bill specify the financing mechanism that States should adopt. It merely requires that it be adequate. Under the House bill, this section would be enforced by requiring that a hospital be located within a State that has a charity and uncompensated care pool as a condition for receiving Medicare.

A comment on that, if I may. First is the risk, however slight, that a State might refuse to set up a plan and thereby deny Medicare beneficiaries access to hospital care. I don't think that is what the committee wants to have happen.

Second, a somewhat less dismal but more likely prospect is that a State could, under the bill, enact a provider tax to fund a plan and then just continue or drastically reduce State and local tax support for indigent health care. The maintenance of State and local tax efforts should not be a State option but should be part of the definition of a qualified plan. Moreover, the method of financing uncompensated health care plans should be more clearly delineated to ensure that responsibility does not lie solely among hospitals but is shared among all sectors of the society, in other words a broad-based kind of tax plan.

The third problem is that the plan would be required to cover only hospital costs, so there would be no incentive for development of alternative delivery systems.

Fourth, the bill does not define adequate payment levels, permits States to establish their own criteria for how unreimbursed costs will be determined and permits the States to set certain levels for charity care participation.

Mr. Seidman touched upon the definitions of bad debts and so forth, and I won't repeat that.

The other thing that we are concerned about is the narrow misreading of the charitable mission of hospitals which properly includes not only indigent care but also health care for nonindigent and social activities of the community at large. We would be concerned if an exclusion like Hill-Burton obligations were in there, that would stop a hospital from keeping its tax-exempt status.

In conclusion, we appreciate the opportunity to meet with the committee on this important piece of legislation. We think it is one of the most important pieces to come out in a long time. This is the first recognition that I know of in my years in Washington the Federal Government has of the uncompensated care problem. We applaud the sponsors for their foresight and interest in the indigent care problem, and as I pointed out, many of the approaches are some that we recommended.

We consider the proposed bill a first important step, and we look forward to working with you as a committee to make sure that it gets passed. Thank you.

Chairman STARK. Mr. Goldbeck.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

[The prepared statement begins at p. 51.]

Mr. GOLDBECK. I am Willis Goldbeck, president of the Washington Business Group on Health. You made a comment in your opening remarks that this indigent care problem was unique. I think it probably is not unique in that we are dealing now with the fastest growth in under-65 poverty in the United States in many many years.

The increase in the number of homeless, hungry, and illiterate are ultimately linked to the medically indigent. I say that because I think it is essential that any of us who are grappling with this issue recognize that it cannot in its entirety be resolved by any health policy. It extends way beyond that.

A second point is that employers have a very high stake in making the increase in market forces, the competitive medical system work. They cannot do that unless the market will work for everybody, and, therefore, we have an obligation to become part of the process in closing the gaps that currently leave people unnecessarily out of the system.

Having said that, I will comment on a few of the specific provisions in the bill. The employers, as you can well imagine, do not rush forward to embrace the idea of extended benefits. Right now we are looking at over 100 different benefit mandates and extensions at the Federal and State level simultaneously. So this is not a single item, nor can it be viewed in that context.

Having said that, however, our organization, and I stress that this is our organization, not all employer organizations, has accepted the idea of the 4-month extension of benefits as being a legitimate responsibility which we can undertake. We are, however, a large business organization, and that extension of benefits, when applied to the smaller businesses, does become yet one more barrier to getting them into the system.

The open enrollment proposal is certainly supportable. I hope it is understood, however, that if you combine the open enrollment with the benefit extension that the open enrollment requirement starts after the extended benefit has been concluded.

The small business research objective is laudable, certainly supportable, and should be fundable, but in fact we really know basically what we have to do. It does not take more research to understand that the answer to small business is to not have them buy like small businesses, but rather to have them band together so they can buy like large businesses.

Certainly you ought to be applauded for the provision pertaining to the unincorporated owners and self-employed—entirely appropriate.

The pools are a tougher issue to deal with. No question that we must protect patients and those providers who are legitimately contributing major efforts to serving the financially unprotected. However, as currently constituted, this provision would place a tax only on those employers already providing extensive health insurance. Therefore, it is our recommendation that if you are going to go to a tax cum surcharge system that you apply it to all employers in the United States regardless of whether they have insurance or not, regardless of their size, and explicitly include all levels of government.

If this is, in fact, an income distribution issue, then treat it as such. If you want it to be health insurance only, then we have to grapple with the issue of what constitutes minimum benefits and how to induce people to provide more insurance when, in fact, all the mandates have a clear message to stop providing health insurance.

We have an increasing number of examples of companies around the country, including up to 1,000 employees, that are dropping their health insurance today because they are well aware that the State will simply charge some larger employer to pick up their employees as though they were in fact indigent, which the week before they were not.

We also do not believe we should accept hospital charges as accurate and, therefore, the amount that ought to be paid in any tax or surcharge system. The evidence today of errors—I am not talking about fraud, but just errors in billing, the excess capacity being carried by many hospitals, the fact that hospitals are consistently achieving their highest profitability in recent history in the United States, the issue of bad debt equating to bad management, not to charity—those are all factors that have to be considered before the Federal Government or employers should be put in a position of automatically accepting whatever the charge may be.

Third, the bill as constituted would drive people increasingly into the hospital for care because that is where it would be further subsidized when we are trying to get people out of the hospital into the outpatient setting, away from the high infection areas and where the market can have the greatest impact.

In conclusion, the bill has many laudable components that we are willing to accept and hope that you will proceed with, and I hope that you will take into consideration that the pooling concept should not be designed to punish those who are doing the most nor to encourage employers to avoid or drop existing health insurance but rather should be designed to protect those who are unprotected in an equitable fashion.

Thank you.

[The prepared statements of the panel follow:]

Statement of Bert Seidman, Director, Department of Occupational Safety, Health and Social Security, American Federation of Labor and Congress of Industrial Organizations

The AFL-CIO is pleased to present testimony today in support of H.R. 4742, the Improved Access to Health Care Initiative. We in organized labor share the committee's concern about the dramatic growth over the past five years in the number of citizens without health insurance protection and, thus, without regular access to the health care delivery system. A less obvious problem, but with equally serious ramifications for policy makers, is the shocking jump in the number of individuals who are judged to have inadequate health insurance coverage. A recent study by the Washington, D.C. Government Research Corporation estimated this population to be as large as 50 million. Adding this to the 35 million known to be without any health care protection there is a total universe of 85 million people who do not have adequate access to health care services.

The AFL-CIO strongly believes that the best medicine for this problem would be the enactment of a national health care system, which makes access to basic health care services a right for all Americans. Of all the industrialized countries except South Africa, only in the United States is health care coverage tied to one's job or other source of income and the decision whether to provide coverage left to an individual's employer. Only in the United States are individuals with chronic health care problems locked out of the system because they cannot obtain insurance protection. And only in the United States are children of the working poor and retirees who are not yet eligible for Medicare denied early treatment for potentially serious medical conditions because of a lack of protection and an inability to pay for health care services.

We commend you, Mr. Chairman, and the other sponsors of H.R. 4742 for introducing legislation which could help to provide much needed health care protection for those who are currently uncovered. However, we do have a number of concerns about the bill.

First H.R. 4742 will address the short-term health care needs of the unemployed who, when laid off, not only experience the trauma of joblessness but also lose their link to the health care system. Although we view the requirement that employers continue coverage for four months after layoff as a positive step, it will not address the needs of the 25 percent of the unemployed who have been jobless for more than 4 months. Conceivably these individuals might have a higher probability of obtaining treatment with the enactment of the bill's requirement that states establish a mechanism to provide funding to hospitals to offset bad debt and charity care. However, a study published in the May 1, 1986 edition of the New England Journal of Medicine demonstrates what many health policy analysts have known for some time: that health care indirectly funded in this manner is far less adequate than services provided under public programs, such as Medicaid.

Second, we are concerned that, absent any targeting requirements in the bill for state insurance pools, public hospitals and other facilities serving a disproportionate share of patients without insurance protection may not receive their "fair share" of funds. We believe that the federal legislation should require states to give priority to these institutions.

Third, although the bill attempts to limit what constitutes bad debt and charity care by specifying what would not be reimbursable under this section, it neglects to mention shortfalls as a result of hospital discounts given to large non-governmental payors. We believe that such a provision should be added to bar facilities from shifting the costs of such discounts on to state uncompensated care pools.

Fourth, we believe that somewhere in the bill a definition of "bad debt and charity care" and "underinsured" ought to be spelled out.

Fifth, if Congress intends to allow states to deal with the uninsured and underinsured problem by allowing them to set up a managed system of care, then it should specify what it means by managed care, in addition to requiring some basic quality controls to protect the health of potential participants.

With respect to the issue of requiring employers to contribute to a state pool for individuals who cannot obtain insurance protection because they are chronically ill or at high risk of becoming ill, the AFL-CIO supports the principle underlying this provision that there should be an equitable risk-sharing arrangement to distribute the cost of care for victims of chronic diseases. We have long held that individuals and their employers should not be unfairly penalized for poor health status and would view the enactment of this provision as a positive step forward. Although some states are now considering establishing such a pool, only nine have actually done so.

On the other hand, although the bill sets a maximum on premiums that can be charged to individuals participating in state risk pools, this cap will no doubt become the only rate, leaving us with serious concerns about the potential pool of eligibles who will not be able to afford such coverage. Both the premium and out-of-pocket maximums, which also are certain to become the exclusive amounts may be affordable only to families with relatively high incomes. In the interest of equity, we believe that the committee should consider instructing states to establish a sliding scale based on income for premium requirements, as well as out-of-pocket payments. Currently, the bill would merely not prohibit a state from doing so. In addition, it should be clearly spelled out in the bill that a state may not charge higher rates to those individuals with relatively poor medical histories.

Before concluding our statement, Mr. Chairman, the AFL-CIO would like to inform the Committee that it has been working with a group of its affiliated unions and consumer organization to develop a model initiative of our own to address the needs of the uninsured and underinsured. Our model, which will be available shortly, has a federal and state component. Like H.R. 4742, it would offer states various options for improving access to care. However, we recommend requiring states to establish a public commission, with a majority of its members, health care consumers, to implement such a plan. It would also require that hospitals with the greatest need be targeted for relief from expenditures for bad debt and charity care, and it would set out general guidelines for case management systems. In addition, to the federal component, we are preparing a model state bill that would take the next step and implement the federal guidelines. At the appropriate time we would be pleased to share this model with the Subcommittee and staff.

Again, we would like to commend the Subcommittee for taking the initiative in attempting to improve access to health care services for the uninsured and the underinsured and are prepared to work closely with you to pass this important initiative.

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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

BEFORE THE

SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS

June 9, 1986

SUMMARY

Mr. Chairman and members of the Committee, I am Jack W. Owen, Executive Vice President of the American Hospital Association. The highest priority for our Association, that represents 5,600 institutional and 40,000 personal members, is finding a solution to the growing crisis of medical indigence. In February of 1986 the AHA Board's Special Committee on Care for the Indigent completed its report, Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent, which outlines a series of long-and short-term public and private initiatives which could be adopted to address the problem. Many of the approaches we recommended are also proposed in the Health Care Improved Access Act of 1986 (H.R.4742). For this reason, we applaud the sponsors' efforts, consider the proposed bill an important first step toward solving the problem, and welcome the opportunity to present our views on this high-priority issue.

The proposed bill would attempt to increase the number of insured and to finance care for the remaining uninsured through five measures, most of which are variations of some of the approaches recommended in our report.

- providing strong incentives for states to establish, and employers to support, statewide insurance pools;
- requiring states to establish uncompensated care plans (or to provide, through an HMO or other mechanism, health care coverage to all residents, thereby making an uncompensated care plan unnecessary);
- extending the continuation coverage period of laid-off workers from 18 to 22 months, requiring that premiums for the first four months be paid as they were before the termination, and requiring an open enrollment period for an employee and spouse whenever a spouse employed elsewhere loses a job and therefore loses individual or family coverage;
- permitting self-employed owners of small businesses to take as a business deduction the cost of their individual or family insurance coverage; and
- authorizing demonstration projects on improving access to health insurance for small businesses and the self-employed.

Although we strongly support the concept of this legislation, our support for the current bill is not unqualified. In particular, the Association does not support the House version's enforcement mechanism--barring hospital participation in the Medicare program if that hospital's state government does not establish an uncompensated care plan. We also believe that the legislation lacks specificity in a number of important areas. For example, the method of financing uncompensated care plans should be more clearly delineated to ensure that responsibility does not lie solely with the hospital but is shared among all sectors of our society.

In concept, this bill is an important step toward averting the indigent care crisis and assuring that those in need have adequate medical care. As with any legislation, however, it will benefit from the close scrutiny and fine-tuning that the legislative process affords, and therefore we have several recommendations of ways the bill might be strengthened and improved.

THE EMERGING INDIGENT CARE CRISIS

Twenty years after the creation of Medicaid, medical indigence is again becoming a major problem for a large and increasing number of Americans, and therefore a major policy issue for federal, state, and local government, providers, and consumers of health care services. A sizable percentage of the population is unable to obtain private insurance and does not qualify for public insurance programs. The persistence of a large population without adequate health insurance coverage imposes large costs on all members of society.

In February 1985, the Board of Trustees of the American Hospital Association established a Special Committee on Care for the Indigent to document the nature and magnitude of the indigent care problem, and to recommend AHA policy initiatives to address this issue at the local, state, and national levels. The committee undertook a comprehensive review and analysis of the causes, manifestations, and consequences of the problem and recommended a variety of long- and short-term actions that government, businesses, insurers, and providers could take to solve it. The final report of the special committee, Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent, was accepted by the Board at its February 1986 annual meeting, and will be sent to members of this committee upon its publication in July.

The report shows a problem of startling and growing dimensions:

- The size and characteristics of the uninsured. In 1983, nearly 33 million Americans were without private health insurance or were not covered by governmental health benefit programs. Nearly two-thirds of the uninsured were employed or were members of families in which the head of the household was employed and often insured. However, the jobs held by the uninsured are frequently marginal. Two-thirds of the uninsured have family incomes less than twice the federal poverty level and one-third fall below the federal poverty guidelines. These characteristics have an important bearing on the extent to which private insurance can resolve the problem of medical indigence.

- The inadequacy of Medicaid. Although Medicaid is often thought to be the principal means of financing care for the indigent, it now covers less than 40 percent of the poor. Medicaid must now be viewed principally as a program of supplementary coverage for the aged and disabled medically indigent who are eligible for and receive benefits under Medicare.

  In 1984, barely one-fourth of Medicaid's expenditures paid for care needed by the non-Medicare eligible poor. Three-quarters of Medicaid's expenditures paid for services provided to individuals already covered by Medicare: primary care and other acute care services not covered by Medicare; extended long-term care for Medicare beneficiaries; and Medicare Part B premiums.

- Rapid growth of unsponsored care. At the same time that Medicaid has been providing coverage for a declining percentage of the poor, the amount of uncompensated care provided by hospitals has risen sharply. State and local government tax appropriations have not kept pace with the growth in uncompensated care. Unsponsored care--the care that must be subsidized by the private sector--more than doubled between 1980 and 1984. In 1984 unsponsored care amounted to $5.7 billion or 4.6 percent of total hospital expenses, up from 3.6 percent of total expenses in 1980.

- Declining sources of private subsidy. Traditionally, hospitals have been compelled--and have been able--to subsidize the cost of care provided to the medically indigent by increasing charges to privately insured patients and patients able to pay their own bills. Between 1980 and 1984, the ability of hospitals to subsidize non-paying patients declined sharply. The principal sources of government financing, Medicare and Medicaid, provide no subsidies for the costs of indigent care. As competitive pressures on private insurers and providers increase, private sources of funds will continue to diminish.

The committee concluded that these trends threaten to limit access to care by the poor and therefore jeopardize the viability of the competitive approach to health care. In an increasingly competitive industry, those hospitals serving substantial numbers of the indigent will be unable to survive without explicit public support. If a method of financing care for the medically indigent within a competitive system cannot be found, pressures to return to more regulatory methods of controlling costs may be irresistible. The committee recommended a variety of long- and short-term measures to avert this crisis.

SOLVING THE INDIGENT CARE PROBLEM: LONG-TERM APPROACHES

Medical indigence is a complex, multi-faceted issue that has no single, or simple, solution. Because the public expects needed care to be provided regardless of a patient's ability to pay, all members of society must participate in the financing of care provided to the medically indigent. This public responsibility does not mean, however, that government alone can or will resolve the problem. An enduring solution to the problem of medical indigence will require initiatives by both the public and private sectors to:

- reduce the size of the medically indigent population through adequate private health insurance; and

- restructure and extend public programs to finance care for the medically indigent who are unable to obtain private insurance.

Private insurance can be made more widely available through the cooperative efforts of federal, state, and local government, private insurers, employers, and providers. However, as competition increases and resources become more constrained, a residual public program is essential to finance care for those who cannot obtain private health insurance. To strengthen the public financing of care for the medically indigent, several actions should be pursued:

- The reorganization of Medicaid into three distinct programs: a program of acute care coverage for the medically indigent who are not eligible for Medicare; a program of supplementary acute care coverage for Medicare beneficiaries; and a program of long-term care coverage for Medicare beneficiaries.

- The gradual strengthening of the federal role in funding Medicaid: a Title XIX trust fund sponsored by a broadly based tax, for example a payroll tax. Such a tax could provide a stable source of funding for Medicaid, would equitably distribute the cost of the program, and, properly structured, could create a positive incentive for employers and employees to obtain private health insurance.

- Reform of delivery and payment systems: the adoption of innovative payment and delivery arrangements would encourage the efficient use and production of the health care services needed by individuals enrolled in Medicaid.

AVERTING THE INDIGENT CARE CRISIS: SHORT-TERM INITIATIVES

Although the elements of a long-term solution to the problem of medical indigence can be readily identified, adoption and implementation of a comprehensive solution will take time. It is essential that there be no deterioration of existing programs during these deliberations. Moreover, while the debate over the long-term solution proceeds, the issue should be dealt with through a series of incremental steps that strengthen incentives to provide employer-paid health insurance and that gradually strengthen public programs.

Initiatives to Promote Private Insurance

The federal government should strengthen, and not reduce, tax incentives that encourage adequate private insurance.

- Personal income tax incentives: Individuals should be permitted to exclude employer-paid health insurance premiums from taxable income, or to deduct employee-paid health insurance premiums from taxable income, only if the health insurance policy covers all dependents. Current limitations on the tax deductibility of employee-paid health insurance should be rescinded, and the deduction should be made available to all individuals, not just those who itemize deductions.
- Corporate income tax incentives: Health insurance premiums should be deductible as a business expense by employers only if the employer pays for coverage of dependents or offers employees the opportunity to purchase such coverage.

In addition, to address the problems created by the loss of health insurance coverage during periods of temporary unemployment, employers should be required to continue insurance coverage for laid-off workers as part of unemployment compensation.

States should encourage the formation of multiple-employer insurance arrangements in an effort to extend insurance to the self-employed and to employees of small firms.

Private insurers, employers, and providers should work to create innovative financing and delivery systems that increase the availability of affordable insurance, particularly for small employers.

Initiatives to Improve Public and Private Funding

Under no circumstances should the federal government reduce the level of federal funding available to state Medicaid programs, nor should it mandate or allow states to reduce entitlement under Medicaid. In addition,

- The expansion of Medicaid eligibility should be accomplished as federal resources permit, with the objective of achieving a uniform standard of eligibility under state Medicaid programs by 1990.

- The federal government should phase in the long-term reforms in Medicaid described above, including the creation of a stable, dedicated source of funding.

- To encourage provider participation in Medicaid and to eliminate the need for private-sector subsidies of Medicaid expenditures, Medicare and Medicaid payment levels generally should be comparable to those for private patients, that is, the ratio of payments to costs should be approximately the same for public and private payers, although the methods of payment may be different.

States should maintain eligibility and funding levels for Medicaid and other programs designed to finance care for the indigent. As their resources permit, states should expand Medicaid coverage to include both the medically needy and other segments of the medically indigent population.

States should establish risk pools for high-risk or uninsurable individuals. All insurers should participate in such risk pools, including Blue Cross plans, commercial insurers, and self-insured businesses. The federal government-should facilitate this by modifying the exemption of self-insured employers from state laws regulating the business of insurance.

Local government should maintain or increase funding for public or other government-supported providers. Within metropolitan regions, governments should identify methods of expanding the population base responsible for funding public providers. Local government should also evaluate the possible benefits of adopting formally organized systems for delivery of care. Employers and insurers should work with government to ensure adequate funding for the medically indigent who must rely on public support. If adequate public funding is not made available, employers should work with providers and insurers to establish funding mechanisms for care provided to the medically indigent.

Hospitals should maintain their historical commitment to provide care to those who need care, including the indigent; should take appropriate actions to raise public awareness of the implications of purchaser actions on the ability of the hospital to care for the medically indigent; and should work with employers, insurers, and government to develop viable short-and long-term solutions to the problem of medical indigence.

AN IMPORTANT FIRST STEP: THE HEALTH CARE IMPROVED ACCESS ACT OF 1986, H.R.4742

H.R.4742, like its similar companion bill introduced by Senator Durenberger as S.2403, takes the form of an amendment to the Internal Revenue Code. A third bill (S.2402) introduced by Senator Kennedy contains many of the same provisions but takes the form of an amendment to the Public Health Service Act. All three versions include variations of several approaches recommended by AHA's special committee, although we have some reservations about each of the bills. Our comments focus on the five substantive sections of the House bill.

Sec. 2: Incentives for the Establishment of Statewide Insurance Pools

Description

This section would use federal tax law as an incentive for large non-governmental employers (over 20 employees) to belong to a "qualified" state pooling association or to purchase insurance from an entity that does. Employers with a "group health plan" who are not members (either directly or through their insurers) would pay an excise tax of 10 percent of the employee health expenses "paid or incurred" during the taxable year. The Internal Revenue Code definition of "group health plan" includes self-insured businesses as well. Because this involves federal tax law rather than state insurance law, self-insured plans could not be exempted through ERISA.

A "qualified pooling association" would be a nonprofit corporation established under state law, open to membership by insurers, hospital and medical service plan corporations, HMOs, employers, and other health financing entities. Although none of these groups would be required to participate, the incentive to do so would be strong. Employers purchasing group coverage from a non-participating insurer, for example, would be subject to the 10 percent tax. The pooling association would offer to any state resident not eligible for Medicare a level of insurance coverage typical of that provided through large employer groups, with specific federal minimum standards regarding out-of-pocket expenditures, maximum lifetime benefit, etc. Pre-existing conditions would be covered after six months of enrollment.

The pooling association would charge a pool premium rate expected to be self-supporting based upon "a reasonable actuarial determination of anticipated experience and expected expenses," but in no event to exceed 150 percent of average state premium rates for individual policies with comparable coverage. Any losses would be assessed "equitably" among all participating members. States or other entities could provide part or all of an enrollee's premium, based, for example, on the enrollee's income.

The Senate bills parallel the House bill on this section, except that the Kennedy bill (S.2402) would enforce this section through a 10 percent civil penalty rather than a tax.

Comments

This proposal has several advantages. First, it would spread the cost over a fairly wide base, including self-insured businesses. Second, it would insure not just high-risk individuals, but anyone able to pay the premium and, at the option of the state, some of the working poor and/or unemployed as well. As in AHA's approach of an expanded Medicaid plan, a large number of enrollees would be able to pay their own way. Third, small firms (who might find the tax particularly burdensome) would be excluded from the requirement.

The major disadvantage would be that, in contrast to AHA's approach, the bill would place the burden on already-insured firms without taxing uninsured firms. To the extent that state plans include subsidized premiums, the result would be that companies that insure their employees could be subsidizing those that do not, and insurers could be subsidizing a product that competes with their own. This could tempt some firms to drop their insurance coverage and some private insurers to back away from the individual and small group plan market. At present, very few firms fail to offer insurance: 12 percent of those with 20-49 employees and 7 percent of those with 50-100, according to a 1985 National Federation of Independent Business survey. Almost all firms with over 100 employees offer health insurance. The bill should be amended to provide some sort of comparable tax incentive to these non-insuring firms. The committee also should take care that the state pools are constructed in such a way that they do not result in less access to private insurance on the part of individuals and small groups.

A related problem is that the bill would exempt federal, state, and local government agencies from the pooling requirements, which again would increase the burden for insured employers. We suggest that the Committee reconsider the appropriateness of such an exclusion, since it seems inequitable to ask insurers and insured businesses alone to be at risk for any necessary subsidy of the state plan.

A third problem is that employers in states that fail to set up a risk pool (and employers who opt out of risk pool membership) would be taxed, yet the tax money would not necessarily be targeted to the medically indigent. The bill should specify that federal tax money collected under this authority would be earmarked for programs addressing the health care needs of the medically indigent in those same states.

A fourth problem is that employers would not be able to determine in advance what their "assessment" to cover losses would be, so they might be tempted to avoid the risk by paying their 10 percent tax, an outcome that would be particularly unfortunate if the tax revenues are not earmarked for health care. This could be remedied by establishing the equivalent of the 10 percent tax as a ceiling on any particular employer's assessment.

Sec. 3: Requiring State Plans for Payment for Uncompensated and Charity Inpatient Care

Description

Sec. 3 would require states to establish uncompensated care plans or to provide, through an HMO or other mechanism, health care coverage to all residents, thereby making an uncompensated care plan unnecessary. The state plan would have to provide for payment for unreimbursed costs incurred by each hospital in furnishing medically necessary inpatient and outpatient services, but the state would have considerable flexibility regarding how such costs would be determined. Payment could not be provided for care counted toward a hospital's Hill-Burton obligations, or that relates to "obligations to pay taxes," or for care to Medicare or Medicaid patients. Also disqualified would be care for which charges can reasonably be expected to be collected with suitable collection mechanisms. The plan could not establish a legal or regulatory limit on the amount of charity or unreimbursed care a hospital may provide. The bill does not specify the financing mechanism a state should adopt, but merely requires that it be "adequate."

At the state's discretion, the plan could limit reimbursement for small (under $250) unpaid deductible or coinsurance bills; require continuation of state and local taxes previously allocated to charity and unreimbursed care, at the levels in effect in 1985 (with appropriate adjustments for inflation, etc.); and require that hospitals participating under the plan provide a certain level of charity and unreimbursed care and meet minimum standards in its efforts to collect unpaid bills.

Under the House bill, this section would be enforced by requiring that a hospital be located within a state that has a charity and uncompensated care pool, as a condition for receiving Medicare. S.2402 would deny Public Health Service Act funds, while S.2403 would reduce the level of federal financial participation for state Medicaid administrative costs from 50 percent to 25 percent, and ultimately to zero.

Comments

The advantage of this section is that it would virtually force states to establish charity and unreimbursed care plans for hospital care. The actual language, particularly in the House bill, presents several problems, however. First is the risk--however slight--that a state might refuse to set up a plan and thereby deny Medicare beneficiaries access to hospital care. Such an outcome obviously would not be in anyone's interest, and, for this reason, the enforcement mechanism of either of the Senate bills would be better than the House version.

Second, a somewhat less dismal but more likely prospect is that a state could, under the bill, enact a provider tax to fund the plan and then discontinue or drastically reduce state and local tax support for indigent health care. The maintenance of state and local tax efforts should not be a state option but should be part of the definition of a "qualified" plan. Moreover, the method of financing uncompensated care plans should be more clearly delineated to ensure that responsibility does not lie solely with hospitals but is shared among all sectors of society. Hospital taxes may work severe hardship on hospitals serving large numbers of Medicare and Medicaid beneficiaries, as any tax must be shifted to privately insured patients.

A third problem is that the plan would be required to cover only hospital costs, so there would be no incentive for the development of alternative delivery systems. The AHA believes that uncompensated care plans should cover primary as well as hospital care, but only if responsibility for funding the plan is broadly spread. Spelling out an equitable and adequate financing plan would enable plans to appropriately cover these primary care costs.

Fourth, the bill does not define "adequate" payment levels; it permits states to establish their own criteria for how "unreimbursed costs" will be determined; and it permits states to set certain levels of charity care as a condition of participation. In combination, these provisions could force hospitals to choose between receiving no support under the plan and receiving very inadequate state payment for a much higher required volume of charity care. We believe the language of the bill should be more precise in its delineation of "adequate" payment levels.

Fifth, some of the other language in the bill would also have to be more precise, to avoid inappropriate regulatory interpretations. For example, the bill should be more exact about what kinds of bad debts would be reimbursable. Community pressures--and hospitals' own ethical concerns--preclude hospitals from using many bad debt control and collection procedures commonly, and appropriately, used by other business.

Sixth, the bill is not clear about what the exclusion of reimbursement for "obligations to pay taxes" means. One possible interpretation is that the bill is anticipating enactment of state laws that require a hospital to provide some specified amount of charity care as a condition for receiving tax-exempt status, and is precluding hospitals from receiving reimbursement for any such legally mandated care. This would be very inappropriate, for two reasons. First, any such law would constitute a narrow misreading of the "charitable" mission of hospitals, which properly includes not only indigent care, but also health care for the non-indigent and a myriad of other social and educational services for the community at large. Second, such an exclusion (like the bill's exclusion of Hill-Burton obligations, which we also consider inappropriate) ignores a fundamental fact about unsponsored care. Unsponsored care provided to fulfill a legal obligation costs a non-profit hospital just as much as unsponsored care provided to fulfill a hospital's own mission. In either case, the hospital must pass these costs along to private payers, or, if it has few private payers, deplete its own assets and therefore jeopardize its ability to continue to serve the population as a whole.

If the bill in fact is referring to an exclusion of new legally mandated charity care, therefore, we would object, just as we object to its exclusion of Hill-Burton obligations.

Sec. 4: Temporary Extension of Coverage for Laid-Off Workers and Open Enrollment for Spouses of Unemployed Workers

Description

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires, as a condition for deductibility of employer contributions to health care plans, that all employers (including self-insured plans and state and local governments) with more than 20 employees provide 18 months continuation coverage for terminated employees and their dependents. Employers are exempt from this requirement only if termination occurs by reason of the employee's gross misconduct. They also must provide three years continuation coverage for widows, divorced spouses, spouses of Medicare-eligible employees, and dependent children who become ineligible for coverage under the plan. Conversion options also must be offered to these beneficiaries if the option is otherwise available under the plan. Employers are not required to pay for such continuation coverage, however.

Sec. 4 of H.R.4742 builds on these changes. For terminated employees in large (20+ employees) companies, it would extend the continuation coverage period from 18 months to 22 and require that premiums for the first four months of this coverage be paid as they were before the termination. The bill also attempts to close another coverage gap by requiring an open enrollment period for an employee and spouse whenever a spouse employed elsewhere loses a job and therefore loses individual or family coverage.

Comment

AHA believes that the provision of continuation coverage is an important step in addressing the insurance problems of the short-term unemployed, and therefore we are pleased with the changes introduced by COBRA, the proposed extension of continuation coverage to 22 months, and the open enrollment period for employees and spouses following a spouse's job loss.

We also support, in principle, the proposal in H.R.4742 to require that the employer share of the premium be continued for the first four of these months, because employees who lose their jobs are seldom in a position to continue such payments on their own. On the other hand, we have some concern that this requirement could prove a hardship to some employers, particularly those in the 20-49 employee range, and therefore could lead some employers to lower their customary premium contribution for all employees, or even to drop their insurance coverage altogether. We suggest finding a way to keep this provision while guarding against some of these potential unintended side effects. For example, the bill might grant hardship exemptions to companies meeting certain tests, such as businesses with 20-49 employees and either very high employee turnover or very low profits.

Sec. 5: Deduction Allowable for Certain Group Health Plan Contributions by Self-Employed Individuals

Description

Sec. 5 would amend the Internal Revenue Code to permit self-employed owners of small businesses to take as a business deduction the cost of their own individual or family health insurance coverage. There are several restrictions to this: (1) the deduction cannot exceed the taxable income the employer receives from the business activity; (2) the health plan offered must benefit all full-time permanent employees not covered by another group health plan; (3) the employer's deduction cannot exceed the lowest employer contribution toward the premium of other employees in the same category (i.e., individual vs. family coverage); (4) the health plan may not be a self-insured one; and (5) one-half of the participants in the plan must be people who are not self-employed employees or their family members.

Comment

Self-employed workers, including those who operate small businesses, are a very significant component of the uninsured population, and therefore AHA supports this effort to make it easier for such individuals to insure themselves and their families. However, we believe this measure will be only a step toward solving the problem, because the key issue for most small businesses is their inability to find health insurance at affordable rates.

Sec. 6: Demonstration Projects on Improving Access to Health Insurance for Small Employers and Self-Employed Individuals

The final report of AHA's Special Committee on Care for the Indigent recommends a variety of actions that state and local governments, insurers, employers, and providers could explore to lower the cost of health insurance for small businesses and the self-employed. For these reasons, we were pleased to see that Sec. 6 of the proposed bill authorizes the conduct of studies and demonstration projects on ways to reduce health insurance costs for these groups. On behalf of our membership, we want to express our strong interest in contributing to these efforts.

CONCULSION

I appreciate this opportunity to meet with the committee on this important piece of legislation, and I appluad the sponsors for their foresight and interest in the indigent care problem. As I pointed out, many of the approaches the AHA has recommended are also proposed in the Health Care Improved Access Act of 1986 (H.R.4742). We consider the proposed bill an important first step. We look forward to working with the committee to strengthen and improve the legislation.

STATEMENT OF WILLIS B. GOLDBECK, PRESIDENT, WASHINGTON BUSINESS GROUP ON HEALTH

My name is Willis B. Goldbeck and I have the privilege to appear before you today as the President of the Washington Business Group on Health, the only national organization created by major employers dedicated to improved health policy and cost management strategies.

The Improved Access to Health Care Initiative before us today could be viewed solely as a technical approach to closing some of the gaps in health insurance coverage. To do so would, in our opinion, fail to recognize and give credit to the bill's authors and sponsors for the major societal issues and values which we feel the bill challenges all of us to address.

Taken together, the bill's provisions really speak to two issues: the distribution of responsibility for the provision of health care coverage, and the designation of what constitutes appropriate or needed care. The latter point could be rephrased to form an even tougher challenge: what should society do to improve the health status of our population through the provision of access to health and medical care?

I would urge you to view all proposals through a screen of principles:

A. Closing gaps in coverage cannot be done only at the expense of those who provide and have coverage. A price must be paid by those who create those gaps, whether they do so by omission or commission.

B. Reaching political agreement on the design of a minimum benefit package would provide the basis for subsequently assigning responsibility for the provision of health care coverage. Minimum does not have to mean low quality, or second class service; it does mean we recognize in public policy that a well delivered minimum service is far preferable to no service at all: 37,000,000 people would certainly agree.

C. Emphasis upon acute care is a guarantee of never extricating ourselves from the financial drain caused by the current system. We must have Congressional leadership to establish a new, longer term, investment strategy that gives prominence to prevention, long term care, child care, and mental health.

D. Finally, we must accept a few basic, if unsettling facts:

    1. We can afford whatever health system we want, if we (a) will buy care efficiently, (b) educate the consumer with meaningful price, service, utilization and quality comparative information, and (c) do not overspend on defense or tobacco subsidies.

    2. All gains in cost management by the public and private sectors will be counteracted if we continue to experience rapid increases in the under 65 poverty rate. Producing generations of illiterate, undernourished, emotionally unstable and largely unemployable youth is not the pathway to a healthy nation or economy.

    3. Our retirement system must be restructured to recognize and reward our new achievements in longevity. Neither Medicare, Social Security, nor private employer retiree medical and pension plans will ever be financed adequately to support millions of people for 20-30 years.

As we respond to the specifics of The Improved Access to Health Care Initiative, we do so in the context of these larger issues which must someday be faced directly.

Employer obligation's

Naturally, no employers want to be required by government to give a benefit which is normally left within the purview of management-labor compensation negotiations. Equally obviously, employers cannot deny that workers who lose health insurance during job transitions or lay offs pose a problem for society as well as for themselves.

By maintaining our traditional support for an employment based health insurance system rather than a governmentally controlled national health insurance system, employers must also be willing to do their share to ameliorate the problems faced by those who fall into the cracks inherent in a private sector, increasingly market oriented structure. It was in this spirit that the WBGH supported the benefit extension in Congressman Waxman's bill to provide health insurance for the unemployed. That was in 1983 when unemployment was 10.2% and millions who had been protected by voluntary extended benefit contracts were laid off for so long that they exceeded this protection. The Waxman bill called for a three-month extension, a period of time that was considered adequate to resolve the problem for most laid off workers. Today, unemployment is 7.2 percent. Extended benefits ranging from two to twenty-four months are the norm for many major companies. Progress has been made yet, undeniably, problems still exist.

We have reviewed our position and, despite the progress achieved and the costs to be incurred, agree to continue our support for a three-month extension requirement. We believe three months is sufficient to meet the needs of transitional workers. And, we want to be very clear that we do not believe employers should be asked to protect the long term or permanently unemployed. They represent a different issue in search of a different solution.

The additional eighteen month extension, at the employee's cost, is not considered necessary due to the recent passage of COBRA which contains the same provision.

We also support the open enrollment period for employed spouses of workers who lose their jobs and their health insurance. It is assumed that such enrollment would occur after the laid off worker exhausted the benefit extension mandated by this same bill. The primary benefit obligation should rest with the employer who laid off the worker, not be shifted to the employer who continues to employ the spouse.

Pools

Both pool approaches have merit and would help groups which, by their exclusion from the existing delivery system, pose a threat to the essentially progressive movement toward a more market oriented health care system.

As advocates of market forces we must also be willing to support, politically and financially, mechanisms that bring more people into the market. The health care market will not work for employers unless it can be creatively manipulated to work for all segments of our society.

The WBGH has always believed that employers should participate in legislatively created pools whether or not the company happened to be self-insured and thus technically exempt due to ERISA. We are aware that this attitude is not always accepted.

In the proposals before this committee, the pool designs have two major flaws. By proposing to finance the pools (for all costs above those paid by pool participants) through what amounts to a tax on employers who provide insurance and the employees who share the cost of that benefit, the bill's authors are providing one more direct incentive for small and mid-sized employers to either not start, or to actually cancel, their employee health insurance benefit. This is neither wild conjecture nor a red herring scare tactic.

Today, more than 50% of the medically indigent are employed by companies that have chosen not to provide any health insurance benefit. If you add dependents to this group, some two-thirds of the indigent are connected to the workforce and could normally be covered by these private sector firms. However, these owners prefer to rely on government, either directly or through pool taxes/surcharges on fellow employers, to enable them to gain a competitive business advantage by avoiding health insurance expenditures.

As if this were not bad enough, the rapidly growing number of state and federal government mandated benefit additions and extensions provide clear reinforcement for the employers who decide not to provide benefits.

We have actual reports of employers with up to 1,000 employees who have recently dropped their health insurance plans. They will rely on the state or federal government to provide protection by some form of surcharge/tax on the major employers who are more responsible and maintain their employee and dependent health insurance benefits. What we have is the ultimate irony: the employers who do the most to provide the best coverage to the most people are the only ones who are asked to pay for the workers and dependents of other employers who elect to provide no benefit. The inequity and perverse incentive should be enough to make the bill's authors rethink their approach to financing pools.

At a minimum, the WBGH recommends that any pool surcharge/tax be levied on 100% of employers whether or not they provide health insurance. This would more equitably distribute the economic burden of meeting a societal need.

The second flaw is the basic assumption that the hospital charge for serving the indigent should be accepted by either public or private payers as legitimate. I find little objection by employers to paying a reasonable share of the true costs of meeting the health care needs of the indigent. However, you can appreciate our reluctance to accept hospital charges as having any validity. Consider that:

- Employers often find as many as 90% of large hospital bills to be incorrectly prepared.
- Neither public nor private payers should pay, through indigent care charges, for excess capacity, unnecessary tests, the failure to collect past due bills and other costs which are not the direct result of indigency.
- Teaching hospitals claim they have to be the most expensive. Why, then, is University Hospital in Iowa City, the state's only teaching hospital, less expensive than the typical community hospital in Des Moines? Is the health of the indigent enhanced by having them served in teaching hospitals out of proportion to the rest of society? And, should we, the payors, accept blindly the contention that we should pay whether the so-called uncompensated care charges happen to be?
- DHHS reports that hospitals in general and teaching hospitals specifically have enjoyed the greatest profits in recent history. Why, then, are they not increasing their indigent care outlays instead of seeking subsidies from government and employers?

- Surcharge/taxes that provide hospital coverage reinforce the most expensive and wasteful care giving setting at the very time we are all trying to develop non-hospital based care systems.

This leads to another WBGH recommendation: All the indigent should be served through managed care systems.

In conclusion, any pool system must be designed so it:

1. does not punish those who already are doing the most.
2. does not encourage employers to drop or avoid starting health insurance benefits.
3. does not accept existing hospital charges without a system ~~for~~ accountability, and
4. does not encourage unnecessary hospitalization.

None of these concerns deny the objective set forth in your bill. We only want to improve the process for achieving that objective.

Small business incentives

We strongly support your provision to provide tax incentives that will make it financially easier for self employed persons to purchase health insurance.

The studies you propose are also useful, more because they can focus attention on the subject than for any major discovery they are likely to produce. In fact, we really know the answer to the question of how small business should or can afford health insurance. The simple fact is, most small firms should not try to buy insurance separately. The product offerings are not very good and the prices are much too high for the value received. Small firms need to band together so their health insurance buying power equals that of large employers.

In some respects, this approach is like the old Blue Cross community rated plans which pool the experience of many small firms and individuals. However, there are two essential differences. The first is that the initiative is taken by the employers who form their own purchasing organization. Secondly, if employers band together, they form a group that does not have to include non-working individuals who are often high users in truly community rated plans.

Let me offer a local example. The WBGH is a very small business (less than 25 employees) and we have developed a remarkable capacity to be non-profit! We do not need extra expenses and we have no for-profit products to price so overhead like health insurance gets passed on to the consuming public. We tried to buy health insurance and found no satisfactory options. Now, we belong to the plan established by the Washington Council of Agencies. We saved at least 20% and received a better benefit. And, we were just notified that the premium increase for 1986-87 was 0%! Yes, it is possible for any small business, with a little planning, to afford a reasonable health plan.

Large employers, separately and through local coalitions, industry associations, Chamber of Commerce or universities can help small employers and their associations with purchasing, negotiations, cost management and benefit administration.

To conclude, we support many aspects of The Improved Access to Health Care Initiative and hope that you, in turn, will give our concerns the attention we feel they deserve. Employers will have to join community and nationwide efforts to make the health care market work for all, but this laudable goal will not be achieved by increasing the incentives for some employers to drop their benefits altogether.

Chairman **Stark**. First of all, thank you all for your generous and kind comments and your thoughtful and constructive criticism. It is my understanding that we would cover outpatient procedures, and whether that makes the emergency room the physician of first option is a question, and that still doesn't solve the problem.

Because of the unfair cost-sharing issue, let's for a minute take a system we are all familiar with that is in place. How would you feel as a panel if we charged for this the same way we do for unemployment insurance, without adjusting on experience. That gets everybody into the box equally, does it not? Do you want to start, Bert? I use this as an alternative.

In the comments about what is fair and not fair, and pushing people toward dropping insurance plans and so forth, so you don't impact on that, what if we just had an employee tax, as we do in unemployment insurance?

Mr. **Seidman**. In effect, we tried to do that with the extension of unemployment insurance to cover the unemployed. The bill that was passed by the House of Representatives would have provided for the extension for 4 months, and then for those who either didn't have health insurance before or for beyond the 4 months——

Chairman **Stark**. Not just for the 4 months portion, but for those areas where we have to raise money.

Mr. **Seidman**. I think the point that is being made by both of these gentlemen is absolutely correct, and that is that there is no reason why people who have self-insurance, for example, should not be paying toward the cost.

Chairman **Stark**. We have covered several insured plans. The employers say to hell with it, let's have no plan. That is one way to get out from under, and what I am hearing suddenly, Jack and Mr. Goldbeck, is that this might be the straw that breaks the camel's back by saying, "OK, this is the last step, and we won't have any program for our workers." After which you will come in and organize them the next day.

Mr. **Seidman**. I guess the anomalous situation that would arise is that people would not have coverage for health insurance until they became unemployed and on the day they became unemployed, they would have coverage for health insurance. The problem is that we are trying to do these things in indirect ways, because we think that the direct ways are not politically acceptable. They may not be politically acceptable. I don't know. But when you try to do them in indirect ways, you inevitably create inequities, in the first place, and inefficiencies, in the second.

If the small employer organizations would support this, then we certainly would not oppose it.

Mr. **Goldbeck**. The more you are mandating the components of private sector health insurance and who gets it, the closer you are coming to designing what the private sector has to provide. That is not a direction which many people in the private sector want to go, but it is where you are headed. We find that, among the largest companies that we work with, many are more inclined today to accept the idea of having all employers participate rather than having a relatively small number of them be given additional surcharges to cover employees from other firms. That is one step removed from being willing to come forth and recommend a specific benefit design that would become a national benefit for everybody to use.

Mr. **Owen**. One of the real problems, I think, is that the employer is going to end up paying for this anyway, because there is no such thing as free care. So that if a hospital has to be paid in some fashion for the care that is rendered to those patients who are not covered by insurance, then those who pay insurance get a higher price in order to cover that. They end up paying the dollars anyway, and that is what I think you are driving at.

Chairman **Stark**. This is just an instinct. We are going to hear testimony later from people who haven't joined with your group, saying "Hey, this puts a burden on large employers to increase their premiums to cover this."

I think what you are getting at is if you are in a one-industry town, then aren't you really lowering the cost of your present program, because you are picking up some of the indigent care or the cost of providing in a charitable way to the person who becomes unemployed. If you take a long-enough-range view of this, it is a closed system. The community is paying all the medical costs one way or another, and if we spread it on one major employer, the one-mill town, do these costs just get lost someplace?

Mr. **Owen**. I think that is pretty correct. There will be storekeepers and people like that in the community. The problem with a small employer, the store owner, the less than six-person business, is that the cost of health insurance is terribly expensive for them. I think that is what Willis was driving at.

We need to give them the opportunity to buy that same kind of health insurance that the large employer can purchase it for, so that they are not in a position of having to pay an inordinate amount of money for their health insurance.

The advantage I see in this approach to the pool is to allow a way for those to get in, but we don't at the same time allow those people to get in by penalizing those who are already in. That is what concerns both of us at this stage of the game.

Mr. **Seidman**. I think the problem has been that we have gotten away from a system which, however inadequately, spread the risk and that was the system of community rating, where the small employer would be paying no more than the large employer to cover his employees.

And to exacerbate that situation, the large employers have explicitly negotiated contracts which absolve them from paying for indigent care. Somehow or other, what we have to do is to get back to at least where we were.

Chairman **Stark**. Before Califano went to work for Chrysler.

Mr. **Seidman**. So we could begin to spread the care more evenly so that you don't have the situation that the large employers are paying less and the smaller employers are paying more. That is obviously a tremendous disincentive to their being willing to participate in anything.

Mr. **Goldbeck**. You can end up with the same objective without going back to community rating if you have large aggregations of smaller businesses. You don't have to go back to everybody in the same bucket and buying in the same way, because if you do that, you have no way to differentiate markets.

Chairman STARK. Let me call on my colleagues.

Mr. Coyne, do you have any questions you want to interject here?

Mr. COYNE. I just had a question. First of all, I would like to welcome the panelists and thank you for the testimony and ask Mr. Seidman, we are often told that unemployed workers once they become unemployed are well enough on their own to continue their health care coverage and that really this might be superfluous, this effort to take care of the people who are unemployed as far as health care benefits are concerned.

What is the fact of the matter when people find themselves unemployed, and are they in a fiscal position to be able to continue their coverage?

Mr. SEIDMAN. They are certainly not. In the first place, only one third of the unemployed and virtually none of the long-term unemployed are receiving unemployment insurance today. So that when they lose their jobs, many of them are not on unemployment insurance or are on for a very short time.

Second, the unemployment insurance benefit averages only one third of the average wage in the State. That means that the income of the unemployed is very limited and they are certainly not able to pick up not only whatever out-of-pocket costs they had when they were employed, but also the employer's share of the premium, which could have been all or the overwhelming part of the premium.

The result is that the unemployed have no continued health care coverage except to the extent that for some workers, it may be continued after layoff for a period of 30 days or in some cases longer. But when the coverage terminates, they are unable to pay for health insurance, just taking their chance that they and their family can get by without it. Most of them are ineligible for Medicaid, largely not on grounds of income but on grounds of assets, and at the same time are unable to pay for health care. They turn to the public hospitals and other places of last resort to obtain medical care.

Mr. COYNE. Thank you.

Mr. Owen, the latest report we have is that the hospitals throughout the country are making record profits, high profits, doing very well. Why is uncompensated care such a problem, then, if that is the case?

In the area that I represent, in the city of Pittsburgh, we have massive billboard displays about attracting people to come to their hospitals and it seems these efforts are a waste of money that may be doing something for uncompensated care.

Mr. OWEN. Let me comment on the so-called profit reports. Most of this stems from the IG report that came out just a few weeks ago.

The problem with that is that it is only looking at Medicare, No. 1, and the total revenues of a hospital, that does not take into account any of the losses on uncompensated care. That might be just what Medicare paid versus what the costs were.

Also, those are 1984 figures, and in 1984, the hospitals did very well on the price that Medicare gave to the hospitals in addition to their costs. They made some one-time cost cuts.

The problem is that since 1984, we haven't had any market basket increases in payments for hospitals; they have been cut back. We had about a 4 percent in 1985, less than a quarter percent increase this year, which is going to be taken away, and they are talking about a half a percent for next year or a freeze.

So that we have gone through 3 years without reaching the market basket, so if you look at what is happening today in the hospital, it is not what happened 4 years ago. I don't argue with what happened 4 years ago.

I argue that if you take any kind of a business and only look at one segment, and say costs and revenue were so much without taking into account the rest of the business and look at total revenue and expenses, you get a skewed picture and that is exactly what has happened.

Mr. COYNE. Thank you.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. I know, Mr. Chairman, you have several panels today, and you need to move along. I notice two of our panelists made reference to the fact that while they applaud the principles of the measure, they have some concern about the financing of the proposed bill or any bill that we consider. If we adopt the approach as recommended by the bill, the burden for paying is going to be placed more heavily on the employers, that is the people who are paying for the programs now.

My question is of a general nature. Will the proposed bill be unfairly expensive to employers? Is there a better way to handle it?

Nobody will deny that access is a serious problem. I think we all do agree to that, but the proposal we have is that the present employers would pay for the coverage, and they are the ones that carry the burden now.

Is this unfair or is there a better way to go about it?

Mr. OWEN. Let me start off. I think that we have to face up to the fact that we are either going to have some kind of a tax situation in which a general revenue tax pays for the uncompensated care, and then you have to define it between bad debts and truly those in need, or look to what is happening out there in the world around us in the competitive world.

It seems to me that if we tackle the problem of those people who are employed and provide a mechanism where those employed have a chance to get some kind of health care coverage, we will lessen the impact that is needed for those who are completely indigent and unable to work or can never work. That is what I think is the beauty of the bill; it is dividing that and making it a sizable chunk.

The second portion of the bill which we haven't discussed much here is where the State sets up a fund for the uncompensated care. That will have to come out of some kind of a tax revenue.

We are concerned that it isn't just a tax on hospitals; that that portion comes from a broad segment of society through some kind of a general kind of taxation rather than just taxing the hospitals and saying there is a hospital sick tax and that is going to be the way we will pay for the uncompensated care.

On the two thirds of the uncompensated care, which are employed people, we would like to see the business community and the private sector take a role in providing health care for those people and to make it possible for the small employer to buy health care at the same price that the large employer does.

Because, after all, as we mentioned earlier, there is a shifting that takes place and somebody has to pay for it, and if it is done in a proper fashion and in a way which can be done competitively and it can be done in a way in which business has a chance to have choices, it seems to us to be a much better approach than just having a tax on everybody to do it.

To get back to the hard care of the indigent, we will have to do something there with taxes.

Mr. GOLDBECK. It is not only unfair but also unproductive. It has the direct result of inducing employers to stop providing health insurance, which can't possibly be what the committee wants. I know it is not the objective of the sponsors.

It is hard to separate the impact of this one proposal from the array of proposals being implemented at this time. We have no analytical capacity to make that finite delineation so that when you have several Federal mandated benefit proposals coming into force, plus the reconciliation act—COBRA—extension of benefits coming into force, plus over 50 State mandated benefits coming into force, I can't tell you the precise proportion this one additional item will have. It is part of a process which is disquieting for all of us who believe that the private sector ought to be providing insurance but see the mandates causing an increasing number of employers to drop out of the system.

It is equally unfair, I think, when you find that over 50 percent of those whom we call medically indigent are in fact employed by somebody. Their employer decided of their own volition that it gives them an economic business advantage not to provide health insurance because somebody else, another employer, is going to be mandated either by the States or the Federal Government to pick up their share.

You need to recognize that the nervousness of the business community does not come from the lack of willingness to contribute to health care in America; most of the hospitals have been built in a large degree, sometimes too large a degree, by business contributions and the extent of health insurance is very evident in the large business community. The problem is that we find the definition of what constitutes indigent, and thus the potential size of the pools you are asking employers to fund very uncertain, and potentially very large.

The study reported by the Washington Post today from the National Center for Health Services Research stipulates that a health care expenditure of 5 percent of a family's gross income means that they have had catastrophic medical expenditures that they could not afford.

That means for a $50,000 a year person, $2,500 in medical expenses would make them medically indigent. It skews the concept, and would add 16 million people to the pools which your bill would create, so there are sound reasons why business is looking at this with a great deal of caution.

Mr. PICKLE. Thank you, Mr. Chairman.

Chairman **Stark**. To the extent that you all haven't answered your objections with alternative suggestions in your testimony, I would encourage you to do so because I do think we have a chance in this Congress to make a step toward—I don't think we are going to abolish the problem, but I think we can make a step in the right direction and the committee wants to be sure we move in that direction. We would like to continue going in the years ahead, and not spoil the chance to build on this first step toward resolving these problems that we all agree exist. How can people of good will get together and achieve a compromise solution?

I appreciate your helping us do that, and I will look forward to working with you and having you help the committee as we deliberate.

Thanks very much.

Chairman **Stark**. Our next panel consists of Patrick Killeen of the UAW; Dr. Leon Wyszewianski, University of Michigan School of Public Health; and Gail Wilensky from Project Hope.

I will let you proceed in the order you are mentioned on the witness list.

Where do we have Patrick Killeen? Do you want to start off?

STATEMENT OF PATRICK F. KILLEEN, ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA [UAW], ACCOMPANIED BY ALAN REUTHER, ASSOCIATE GENERAL COUNSEL

[The prepared statement begins at p. 67.]

Mr. **Killeen**. I am Patrick Killeen, assistant director and senior health care consultant for the Social Security Department of the International Union, United Automobile Workers.

With me is Alan Reuther, the associate general counsel for the UAW.

The UAW appreciates the opportunity to testify before this subcommittee concerning the proposed Health Care Improved Access Act of 1986, H.R. 4742. I appear on behalf of 1.5 million active and retired UAW members, including many thousands of UAW members who have lost their health insurance coverage due to unemployment. We commend this subcommittee for addressing the unmet health care needs of uninsured individuals, one of the most serious problems we face as a nation.

The extent and seriousness of the lack of health insurance is well-known. The Bureau of Labor Statistics estimates that one-third of laid off workers have no health insurance coverage of any kind. This translates into millions of people, including more than 200,000 displaced members of our union, who have lost essential family health protection as a result of layoffs.

The impact of job loss on health insurance coverage is usually immediate. According to a Department of Labor study, close to 60 percent of workers lose their health protection immediately or within a month of layoff, and only 20 percent have protection beyond 3 months.

The limited budget of the unemployed is seriously strained by competing essential priorities. Mortgage or rent payments, threatened utility cutoffs, merely putting food on the table, are the harsh everyday realities. There is no money for health insurance.

As a result, receipt of necessary medical treatment is often ignored or delayed with sometimes serious consequences. A study of laid off autoworkers in Michigan by the Social Welfare Research Institute indicates that 17 percent of laid off workers do not even try to seek needed care. This is a shocking situation.

The Medicaid Program also fails to provide adequate access to health care for the unemployed and uninsured. Although Medicaid provides health care coverage to the poor, because of stringent eligibility criteria it does not cover many unemployed and uninsured persons. According to a recent University of Michigan study, only 25 percent of the unemployed had Medicaid coverage for either themselves or for their children.

There is an urgent need for Federal legislation to improve access to health care for the unemployed and the uninsured. The UAW commends the chairman and ranking member of this subcommittee, Representatives Stark and Gradison, for introducing the proposed Health Care Improved Access Act of 1986, H.R. 4742. We believe that this legislation would represent an important first step in meeting the unmet health care needs of millions of persons in this country. We urge the subcommittee to give this legislation prompt, favorable consideration.

The UAW is particularly pleased that the health care improved access initiative would begin to help alleviate some of the problems faced by laid off workers and their families in obtaining access to health care. Most importantly, H.R. 4742 would require employers to continue health care coverage for at least 4 months after workers are laid off. Employers would be required to continue whatever level of coverage and employer contributions were previously offered to active workers. This would help to bridge the gap in health care coverage for a large segment of the unemployed.

Although the UAW believes that any solution to the problem of health care for the unemployed necessitates some Federal program, the private sector initiative contained in the Stark-Gradison bill would still make an important contribution toward providing improved access to health care for the unemployed.

The health care continuation provisions in H.R. 4742 will actually help to reduce Federal and State expenditures. When employers fail to continue health care coverage for laid off workers, the costs of providing coverage do not disappear. To the extent that care is provided, much of these costs are simply shifted onto other payors—either the Federal and State Governments under Medicaid, or onto the public and nonprofit community hospitals who handle most charity care.

Requiring employers to continue health care coverage for laid off workers will help reduce this cost shifting, and thus will actually reduce Medicaid expenditures by the Federal and State Governments.

The UAW believes that other provisions in H.R. 4742 dealing with the subsidized State insurance pools for the uninsurable and State systems to fund hospital care for the uninsured and the poor represent positive measures. However, we urge the subcommittee to give careful consideration to certain details of these proposals, and we have specific suggestions regarding them in our text.

In conclusion, the UAW would again like to commend Chairman Stark and Representative Gradison for introducing the health care improved access initiative. We believe that this package of proposals represents an important first step toward meeting the urgent problem of providing adequate access to health care for millions of uninsured persons in this country. The UAW looks forward to working with the members of the subcommittee as it considers this important legislation.

Thank you.

Chairman STARK. Thank you very much.

Mr. Wyszewianski.

Mr. WYSZEWIANSKI. My name is Leon Wyszewianski.

Chairman STARK. Could you withhold for a moment. For the folks standing in the doorways, I don't know whether it makes the room calmer to have the doors open or not, but when people talk in the halls, it makes it difficult for us to hear you here. If you could pull the doors closed, I don't mean to shut off anyone from the halls.

STATEMENT OF LEON WYSZEWIANSKI, ASSISTANT PROFESSOR, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN

[The prepared statement begins at p. 72.]

Mr. WYSZEWIANSKI. I would like to thank you, Mr. Chairman, for inviting me to comment on H.R. 4742, the Health Care Improved Access Act of 1986. As indicated in my prepared statement, my comments focus on two specific aspects of H.R. 4742. Both relate to research I have done in the last 5 years. First I would like to comment on health insurance for laid off workers, and then on limits on annual out-of-pocket expenditures in coverage provided through statewide insurance pools.

Health insurance for the unemployed was at the top of the policy agenda 3 years ago, at the height of the worst recession we've had since the Great Depression. Some critics saw this focus on the unemployed who had no health insurance as too narrow. They urged a broadened approach that would encompass the millions of other Americans, most of them employed, who have always lacked any kind of health insurance coverage. In time, as the economic climate improved, attention did shift to the medically indigent, the underinsured and the employed-uninsured, but in the process, health insurance for the unemployed virtually disappeared from the policy agenda.

In that context, I believe H.R. 4742 strikes a good balance. It addresses the needs of the chronically uninsured, particularly the uninsurable, and at the same time it deals with the needs of those who lose their health insurance as a result of unemployment. Extended health insurance coverage for laid off workers, which H.R. 4742 calls for, is highly desirable and much needed. It avoids potential disruptions in how health care is obtained and protects the unemployed from burdensome additional expenses for health care and for premiums.

However, limiting the extension of coverage to 4 months would leave some important gaps. Results of a study of health insurance coverage of the unemployed which we conducted in 1983 showed that, compared to those who are unemployed less than 4 months, people who are unemployed longer than 4 are more likely to have lost their health insurance coverage and to remain uncovered. Most of them do not even have Medicaid. This was mentioned earlier today.

At the same time they are more likely to experience the growing financial and emotional stresses associated with prolonged unemployment.

Ideally, everyone would have unbroken health insurance coverage while unemployed. Short of that, however, and being mindful of the emphasis on not adding new burdens to the Federal Treasury, I would favor continuing health insurance for at least as long as unemployment benefits, which are provided for up to 26 weeks. When the unemployment rate is high, unemployment benefits are provided for periods up to 55 weeks, decreasingly so, but that is still true. I propose that at the very least health insurance coverage follow the same pattern.

I would like to comment briefly on the stipulation in H.R. 4742 that coverage provided through statewide insurance pools should have annual limits on out-of-pocket expenses of $1,500 for individuals and $3,000 for families.

If the intent of this requirement is to provide protection against out-of-pocket expenses that are financially catastrophic, the stipulation in its current form can achieve that goal only imperfectly. A $3,000 out-of-pocket expense will not be catastrophic for every family. For some, much smaller amounts can be catastrophic. It all depends on the family's financial situation. For a family earning $60,000 a year, a $3,000 out-of-pocket expense is likely to be quite bearable. But to a family with $15,000 in annual income, an even smaller expense, such as maybe even $1,000, could already be devastating.

I would urge, therefore, that the limits on out-of-pocket expenses be tied at least to income, if not to other measures of ability to pay. That would provide more equitable protection against financially catastrophic expenses, and such protection is needed, given the higher probability that a person covered through an insurance pool will have high health care expenditures and limited financial means.

Thank you, sir.

Chairman **Stark**. Thank you very much.

Dr. Wilensky.

STATEMENT OF GAIL R. WILENSKY, PH.D., VICE PRESIDENT OF HEALTH AFFAIRS, PROJECT HOPE

[The prepared statement begins at p. 76.]

Ms. **Wilensky**. Thank you.

Mr. Chairman, it is a pleasure to appear before the Subcommittee on Health. My name is Gail Wilensky. I am the vice president of health affairs at Project HOPE. I am here today, however, not as a representative of Project HOPE but as a health policy analyst who strongly supports section 5 of H.R. 4742, "Health Care Improved Access Act of 1986."

I have not included in my written testimony the fact that I do not support the extension of health insurance as it is now constructed. I would be glad to speak about an alternative formulation of the extension of coverage if you would like later.

The 1980's have been characterized as the period of the "prudent buyer." All of the major purchasers of health care—the Federal Government, State and local governments, and most importantly the private sector—have concentrated on paying only for what they buy and getting the best price for their purchase. The result has been a shift from implicit to explicit financing. Items such as uncompensated care which were once financed implicitly, that is by cost subsidy, have been placed at risk. While the list of items that used to be implicitly financed includes more than the care of the uninsured, the issues of the uninsured and of uncompensated care are the most visible problems of the change in the financial system.

Who are the uninsured? There is some debate about the number of uninsured in 1984. The number of uninsured reported by the Survey of Income and Program Participation [SIPP] as of the second quarter of 1984 was 30.4 million individuals (unpublished data, SIPP). The number of uninsured, according to the current population survey in 1984, as reported by the Urban Institute, was approximately 35 million (Wall Street Journal, June 3, 1986). While that is a large discrepancy, the fact of the matter is that it will become increasingly more difficult for the uninsured to obtain care in our current financial environment. It is a major problem for 30 million uninsured; it is an even more serious problem if there are 35 million uninsured.

The characteristics of the uninsured, particularly with respect to their employment status, have remained surprisingly consistent since the late 1970's. As we have heard today, 50 percent of the uninsured are unemployed. Estimates of the uninsured who are employed at least part of the year have ranged from 45 to 55 percent of the uninsured population. Estimates of the employed uninsured and their dependents indicate that this group accounts for as much as 75 percent of the uninsured population.

Furthermore, estimates indicate that almost 90 percent of the employed uninsured work for firms who do not offer plans or are employees who are ineligible for the plans offered. These figures indicate that policies which make it more likely that the employed uninsured obtain insurance coverage could dramatically affect the number of uninsured in the population.

Although we do not know as much about why some small employers offer health insurance and others do not, we know that small firms are much less likely to offer health insurance than larger firms and that employees working for small firms are less likely to be insured than employees working for larger firms. According to a recent survey by the National Federation of Independent Businessmen, 32 percent of the firms with under four employees provided health insurance to all employees. Although the percentages varied slightly for firms with 5 employees to 100 employees, overall 50 to 60 percent of these firms provide health insurance to all their employees.

The numbers are different if we look at the number of employees covered, but in any case, the message is clear: Small firms are less likely to offer health insurance coverage and employees working for small firms are less likely to be covered under health insurance. There are several reasons cited by the NFIB study as to why small employers are less likely to offer health insurance coverage, such as the high cost of insurance and high turnover rates, but the inability of some firms to use pre-tax dollars to purchase health insurance is clearly one reason.

Tax policy and the employed uninsured: As many on your subcommittee know, I have been one of several health policy analysts who have argued against unlimited tax excludability of health insurance premiums. But at the same time, there is little justification for not allowing certain segments of the employed population the same tax subsidies enjoyed by the rest of us. Under current tax law, the self-employed and the owners of unincorporated businesses cannot deduct the premiums for their own health insurance plans. This not only means that the self-employed and owners of unincorporated businesses are less likely to be covered by health insurance, but it also means that their employees are less likely to be covered as well.

Section 5 of H.R. 4742 has several important provisions which would correct this problem. Together these incentives should substantially increase the likelihood that the self-employed and their employees obtain health insurance coverage.

How many would be helped under section 5? We cannot estimate with any precision how many of the employed uninsured are likely to obtain insurance coverage as a result of the section 5 provisions. The reason is that it is impossible to find the number of firms by firm size for unincorporated businessmen in addition to those who actually offer health insurance coverage. However, we can see from IRS statistics that they are mostly small firms. That is, 67 percent of the unincorporated businesses have receipts of less than $25,000. In fact, only 10 percent of unincorporated businesses had receipts greater than $500,000. There is little doubt the vast majority of unincorporated businesses are small.

In conclusion, allowing the self-employed and unincorporated businesses to deduct their own health insurance premiums will not help all of the employed uninsured. To the extent that many small employers do not offer health insurance because they face high labor turnover, they have large numbers of secondary workers, or because their employees do not want health insurance coverage, there will need to be specific strategies and solutions to deal with these particular problems.

But to the extent that employers do not offer health insurance because they cannot use pretax dollars for their own coverage, this provision is an important contribution to increasing the health insurance coverage of the employed uninsured. If we as a society believe that Federal tax policy should be used to promote and expand the coverage of private health insurance—and apparently we do—we should extend this benefit to those not now covered. By doing so, we will increase the likelihood that farmers, small shopkeepers and other owners of unincorporated businesses will obtain the health insurance coverage they and their workers so badly need.

Thank you.

[The prepared statements of the panel follow:]

Statement of

Patrick F. Killeen
Assistant Director, Social Security Department
International Union, UAW

Mr. Chairman, I am Patrick F. Killeen, Assistant Director and Senior Health Care Consultant for the Social Security Department of the International Union, United Automobile, Aerospace & Agricultural Implement Workers of America (UAW). The UAW appreciates the opportunity to testify before this Subcommittee concerning the proposed "Health Care Improved Access Act of 1986" (H.R. 4742). I appear on behalf of 1.5 million active and retired UAW members, including many thousands of UAW members who have lost their health insurance coverage due to unemployment. We commend this Subcommittee for addressing the unmet health care needs of uninsured individuals, one of the most serious problems we face as a nation.

The UAW is firmly committed to the principle that all individuals should have access to adequate health care as a basic human right. Unfortunately, this right is not a reality for many Americans.

The extent and seriousness of the lack of health insurance is well known. The Bureau of Labor Statistics estimates that one-third of laid off workers have no health insurance coverage of any kind. This translates into millions of people, including more than 200,000 displaced members of our Union, who have lost essential family health protection as a result of layoffs.[1] The impact of job loss on health insurance coverage is usually immediate. According to a Department of Labor study, close to 60 percent of workers lose their health protection immediately or within a month of layoff, and only 20 percent have protection beyond three months.[2] A recent University of Michigan study shows that in the Detroit area 51 percent of unemployed individuals were without health insurance. Of this group, 78 percent lost insurance as a direct result of having lost their jobs.[3] Those workers who are lucky enough to get new jobs often have to wait months for coverage that is substantially poorer in benefits than their previous coverage. The dimensions of this problem become enormous when one considers that approximately 21.5 million people, nearly 17 percent of the population, will be without work for all or part of the year.[4]

Of all the industrialized nations, only in South Africa and the United States, which have no national health plans, is the tragedy of unemployment compounded by the fear and insecurity caused by loss of family health care protection. The limited budget of the unemployed is seriously strained by competing essential priorities. Mortgage or rent payments, threatened utility cut-offs, merely putting food on the table, are the harsh everyday realities. There is no money for health insurance. As a result, receipt of necessary medical treatment is often ignored or delayed with sometimes serious consequences. A study of laid off auto workers in Michigan by the Social Welfare Research Institute indicates that 17 percent of laid off workers do not even try to seek needed care.[5] This is a shocking situation.

Looking beyond the difficulties of those laid off, we find a problem even more staggering. The number of Americans without any public or private health insurance is now 35 million people.[6] When those who lose insurance protection for short periods of time are included, the total is well over 50 million people.[7] A recent study by the Robert Wood Johnson Foundation found that one million Americans are refused medical care annually because they cannot pay for it; another five million do not even seek care they feel they need because they know they cannot afford it.[8]

Many of the problems we currently face in providing health care for the uninsured have been aggravated by the increasing corporatization of medicine and the Reagan Administration's approach of promoting growth of the for-profit sector in health care. Previously, public hospitals and not-for-profit community hospitals provided care for the uninsured by subsidizing that care through charges made to insured third-party payers. However, the growth of for-profit hospital chains has severely reduced these types of social subsidies for the poor and uninsured. Because of heightened competition in the health care industry, the not-for-profit community hospitals have increasingly been financially unable to continue to provide care for those without adequate health insurance.

Future forecasts call for more of the same. According to Dr. Arnold Relman, Editor of the New England Journal of Medicine, and a leading critic of for-profit health care entrepreneurs, as many as 180 public hospitals were purchased or came under the management of for-profit hospital chains between 1970 and 1980. He also warns that 30 percent of all hospitals will be chain-owned by 1990 if the current rate of expansion continues.[9] The American College of Hospital Administration makes an even more alarming prediction, estimating that by 1990, chains will own 60 percent of U. S. hospitals.[10] This will result in less and less health care being made available to the poor and uninsured, thereby increasing the financial burden on already desperately strapped individuals and nonprofit and public hospitals.

Recognition of the serious plight of the uninsured has spawned a number of voluntary efforts on the part of community leaders, labor unions, hospitals and physician groups around the country to provide some health care services for the uninsured. Several states have also established subsidized insurance pools for those without access to employment based health insurance. Others have established systems to fund hospital care for the uninsured. Although such efforts are commendable, they fall far short of what is needed and many problems remain. These efforts are geographically scattered and uncoordinated; they do not address much of the known need; and they often fail to provide adequate financial support to pay for health care services for those least able to afford it -- the poor and the unemployed -- leaving this financial burden on the already severely burdened public and nonprofit community hospitals.

The Medicaid program also fails to provide adequate access to health care for the unemployed and uninsured. Although Medicaid provides health care coverage to the poor, because of stringent eligibility criteria it does not cover many unemployed and uninsured persons. According to the University of Michigan study, only 25 percent of the unemployed had Medicaid coverage for either themselves or for their children.[3] This problem has been exacerbated by cut-backs in Medicaid promoted by the Reagan Administration. Many unemployed persons are also ineligible for Medicaid because they are first required to deplete assets acquired while they were employed. The UAW submits that no one should be required to become impoverished in order to be able to get access to adequate health care services.

The UAW believes that only the ultimate passage of a comprehensive national health security program will adequately remove the barriers to access to health care for the millions of unemployed and uninsured individuals in this country. We continue to find widespread support for a national health program around the country.

In the short term, there is an urgent need for federal legislation to improve access to health care for the unemployed and the uninsured. The UAW commends the Chairman and Ranking Member of this Subcommittee, Representatives Stark and Gradison, for introducing the the proposed "Health Care Improved Access Act of 1986" (H.R. 4742). We believe that this legislation would represent an important first step in meeting the unmet health care needs of millions of persons in this country. We urge the Subcommittee to give this legislation prompt, favorable consideration.

The UAW is particularly pleased that Health Care Improved Access initiative would begin to help alleviate some of the problems faced by laid off workers and their families in obtaining access to health care. Most importantly, H.R. 4742 would require employers to continue health care coverage for at least four months after workers are laid off. Employers would be required to continue whatever level of coverage and employer contributions were previously offered to active workers. This would help to bridge the gap in health care coverage for a large segment of the unemployed.

Some large corporations already continue health insurance coverage for laid off workers. For example, under major UAW contracts, health insurance coverage for laid off workers may continue for up to two years, depending on length of seniority. But these contractual benefits are not typical for most workers, nor for many members of our Union in independent parts and supplier plants, who often lose health insurance coverage at the point of layoff.

This provision in H.R. 4742 builds upon the health care continuation provisions contained in the Consolidated Omnibus Budget Reconciliation Act, which requires employers to allow laid off workers to continue, at their own expense, coverage under their employer's group health plan for up to 18 months. In addition, widows and widowers, divorced spouses, spouses not yet eligible for Medicare and dependent children have the right to continue coverage under the employer's group health care plan for up to 36 months, again at their own expense. While these provisions are helpful and a step in the right direction, they do not solve the problem faced by the unemployed in obtaining access to health insurance coverage. This cost is simply prohibitive for most unemployed persons, given their already strained family budgets. Indeed, prior to the passage of the group health care continuation provisions in the budget reconciliation measure, only about one percent of the persons in Michigan who lost coverage under their employer's group health care plan elected to convert to individual policies, which typically cost less than group policies because they offer substantially fewer benefits.[11] Accordingly, it is apparent that very few laid off workers will actually be able to afford to exercise their option to continue coverage under the employer's group health care plan, which usually is even more expensive. To make health care coverage affordable for laid-off workers, government or employer contributions are critical.

In 1983, the House passed legislation to provide health care for the unemployed (H.R. 3521). This bill, which was supported by the UAW, would have required employers to continue health care coverage for laid-off workers and also would have authorized funds for a federal program to provide health care for the long-term unemployed. Unfortunately the Senate rejected efforts to provide federal funds for this purpose; however, it never took up the issue of requiring employers to continue insurance coverage.

The health care initiative introduced by Representatives Stark and Gradison would not create a new federal program. Instead, it simply embraces the concept that employers should be required to continue health care coverage for laid off workers for a period of time. Although the UAW believes that any solution to the problem of health care for the unemployed necessitates some federal program, the private sector initiative contained in the Stark-Gradison bill would still make an important contribution towards providing improved access to health care for the unemployed.

The health care continuation provisions in H.R. 4742 will actually help to reduce federal and state expenditures. When employers fail to continue health care coverage for laid off workers, the costs of providing coverage do not disappear. To the extent that care is provided, much of these costs are simply shifted onto other payors -- either the federal and state governments under Medicaid, or onto the public and non-profit community hospitals who handle most charity care. Requiring employers to continue health care coverage for laid off workers will reduce this cost shifting, and thus will actually reduce Medicaid expenditures by the federal and state governments (as well as relieving the burden on public and non-profit community hospitals).

Requiring employers to continue health care coverage for laid off workers will not impose an undue burden on businesses. In most cases, these additional costs will represent only a small fraction of the overall health care expenditures by the employer. And employers always will have the option of pre-funding these liabilities, so that they are prepared for economic downturns.

The UAW would also like to comment briefly on the other sections of the Health Care Improved Access initiative. H.R. 4742 also would give the spouses of workers who lose their jobs the right to enroll in the health care plan offered by the spouse's employer. All too often, whole families lose essential health protection because the spouse with family health care benefits loses his/her job, and the other spouse is precluded from enrolling in his/her employer's health care plan. H.R. 4742 would effectively solve this problem by creating an automatic enrollment window period for the still employed spouse.

The UAW also believes that the provisions requiring the states to establish a system to fund hospital care for the uninsured and the poor are commendable. The need for such state systems has been made even more intense by the increased competition between health care providers, who are compelled to offer less and less care to the poor and the uninsured because of reduced subsidies for such care from Medicare and other third-party payers. Moreover, the establishment of state systems to fund hospital care for the uninsured and the poor would help to alleviate the strain that uncompensated care currently places on public and non-profit community hospitals, whose survival is becoming increasingly threatened. Many of these hospitals are in areas of high unemployment or in rural areas, where they are the providers of last resort for a growing number of individuals.

The UAW urges the Subcommittee to give careful consideration to certain details of this proposal. For example, federal standards need to be included to insure that such systems do not exclude significant numbers of the needy through too stringent eligibility standards or through the use of copayments. Similarly, the level of benefits available under such systems needs to be spelled out in more detail, as well as the provisions dealing with patient ability to pay. The legislation also leaves the states considerable discretion as to the type of funding mechanism which can be utilized. The UAW believes that health care providers, health insurers, and the federal and state governments all should participate in any financing mechanism, in order to assure a complete and successful response to the problem of uncompensated care. We are also concerned that the penalty which would be imposed on states that fail to establish an appropriate system -- denying hospitals in the state the right to participate in Medicare -- could have an adverse impact on health care for the elderly. We urge the Subcommittee to explore other possible penalties, such as denying tax-exempt bonds for hospital construction and equipment acquisition unless there is an appropriate state system to handle uncompensated care.

The UAW also supports the provisions dealing with the creation of subsidized state insurance pools for the "uninsurable". Through such mechanisms, the states can guarantee the availability of health insurance to individuals, regardless of their health status. Currently, there are many individuals who do not have access to employment-based health insurance who cannot obtain private insurance on their own because of pre-existing medical conditions. This proposal would assure that these individuals have access to health insurance at affordable rates. However, we believe that some of the details of this proposal require additional consideration. In particular, we believe that all employers ought to be required to participate in and help share the costs of these state pools, not simply employers that currently offer insured or self-insured health care plans. Otherwise, the states will be in the position of rewarding those employers who choose not to offer any health care coverage to their employees.

In conclusion, the UAW would again like to commend Chairman Stark and Representative Gradison for introducing the Health Care Improved Access Initiative. We believe that this package of proposals represents an important first step towards meeting the urgent problem of providing adequate access to health care for millions of uninsured persons in this country. The UAW looks forward to working with the Members of the Subcommittee as it considers this important legislation. Thank you.

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STATEMENT OF LEON WYSZEWIANSKI, DEPARTMENT OF MEDICAL CARE ORGANIZATION, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MICHIGAN

My name is Leon Wyszewianski. I am an Assistant Professor at the School of Public Health, The University of Michigan, Ann Arbor, Michigan. I would like to thank you, Mr. Chairman, and the Members of the Subcommittee, for inviting me to comment on H.R. 4742, the Health Care Improved Access Act of 1986.

Over the past five years I have been involved in research directly pertinent to some of the issues addressed by H.R. 4742. From 1982 to 1984 I was co-director of a study of health insurance coverage and use of health care services among the unemployed in the Detroit Metropolitan area. More recently I have conducted research on financially catastrophic health expenditures. I am honored to have this opportunity to comment on aspects of H.R. 4742 to which these studies are relevant. I will focus specifically on the issue of extending health insurance coverage for laid-off workers and on limits on annual out-of-pocket expenditures in coverage provided through statewide insurance pools.

EXTENDED HEALTH INSURANCE COVERAGE FOR LAID-OFF WORKERS

The Need for Extended Insurance

H.R. 4742 includes a provision whereby employers would continue health insurance coverage for laid-off workers for four months. This provision raises anew a number of questions that were much debated in 1982-1983, when health insurance for laid-off workers became very salient with the rise of the unemployment rate to levels unprecedented since the Great Depression. At the time, several bills to provide health insurance for the unemployed were introduced in the U.S. Congress, but none were enacted, in part because of uncertainty about the exact nature and magnitude of the problem. Some viewed the loss of health insurance due to unemployment as a temporary phenomenon affecting only a few, while others saw it as a major public health crisis. Neither side, however, could provide definitive evidence to support its claims. Very little was actually known about the effect of loss of employment on health insurance coverage. The only information available was based on extrapolations from studies of general populations that had been designed for other purposes. When we searched the literature in 1983 we found no published studies of an unemployed population that investigated the level of insurance coverage.

In an effort to remedy this deficiency, a group of us on the faculty of The University of Michigan's School of Public Health undertook, with funding from the Robert Wood Johnson Foundation, a survey of unemployed workers in the Detroit Metropolitan area. A total of 1,332 unemployed individuals were interviewed in late 1983 and asked about their health insurance, use of health care services, and health status. Everyone in our sample had received unemployment insurance payments. Therefore our respondents exclude the unemployed who never worked, those who did not work long enough to qualify for unemployment benefits, and those in marginal jobs not covered by such benefits. As a result, our sample was biased in favor of unemployed people more likely to have health insurance. The study's methodology and findings are described in detail in an article which appeared in the July 1985 issue of Medical Care, pp. 847-854.

The findings from our study help address the following questions about health insurance coverage among the unemployed:

What proportion of the unemployed experienced loss of health insurance? In 1983 one widely reported estimate, based on a 1977 survey of the general population, put at no more than 13% the proportion of the unemployed who lost their health insurance in 1982. We found that in late 1983 even among those who had been unemployed for three months or less, the rate was twice as high (26%), and that, of those unemployed between four and twelve months fully half had lost their health insurance. For those unemployed for more than two years, the figure was 70 percent. Although directly comparable figures have not been reported anywhere else, our findings on the overall level of health insurance coverage among the unemployed are consistent with the results from earlier studies of the 1974-1975 recession, and with a May 1983 report by the Congressional Budget Office, as well with two more recent studies of the unemployed, one of Maryland recipients of unemployment insurance benefits, the other of Michigan's automobile industry workers.

What proportion of those who lose insurance are able to gain other coverage through their spouses or through conversion? Some have argued that loss of insurance due to unemployment is less of a problem than may appear at first because most of the unemployed who lose their health insurance are able to get other coverage, either through their spouses, or by converting their group coverage to individual coverage, for which they pay the full premium.

However, we found that only a third of those who lost their insurance were able to obtain any other kind of insurance. Moreover, often such new coverage does not fully restore the coverage lost. Individual coverage provided under conversion policies tends to be more restrictive and more expensive than the group coverage it replaces. Similarly, obtaining coverage under the spouse's policy may also result in additional premiums, different benefits, and even having to seek care from different providers, which can disrupt established patterns of care. Being forced to change providers is increasingly a concern as more and more delivery and insurance mechanisms become linked together in health maintenance organizations, preferred provider organizations, and similar arrangements.

In addition, those unable to get any other health insurance coverage are not, for the most part, covered by Medicaid. Our results show that three quarters of the unemployed who had no health insurance were not covered by Medicaid either. Even those who do get coverage under Medicaid may face a change in health care providers if their current ones do not accept Medicaid patients.

In sum, the findings from our study suggest that loss of health insurance affects a substantial proportion of the unemployed, and that the majority of those who lose their insurance do not obtain any kind of other coverage, not even Medicaid. In addition, even those who do regain coverage are subject to burdensome premiums at a time of reduced income, and to changes in benefits that can disrupt their established patterns of obtaining health care services.

Therefore, extending existing health care coverage for laid-off workers, as stipulated in H.R. 4742, is likely to benefit everyone who would otherwise lose health insurance coverage due to unemployment. That includes those able to get other coverage, for whom an extension of existing coverage obviates changes in benefits and providers, not to mention being spared the financial drain of paying additional premiums.

However, as I will discuss next, our findings also suggest that extending health insurance coverage for only four months may leave without continued coverage some groups that are in greatest need of it.

Optimal Length of Coverage Extension

As the accompanying table shows, we found that the percentage of unemployed individuals who were without health insurance coverage increases with duration of unemployment, and that four months represents a critical point. Of those unemployed three months or less, only 17% had lost their insurance and had not obtained other coverage, in contrast to 34% of those unemployed four to six months. (The percentages for losing insurance, regardless of whether or not other coverage was subsequently obtained, are 26% and 50%, respectively). This pattern most likely reflects the greater proportion of employers who already continue to provide health insurance coverage for three months after a worker has been laid off. The four-month extension of coverage stipulated in H.R. 4742 is therefore more likely to find acceptance among employers, since more of them are already in essential compliance with it. Another argument in favor of only requiring a four-month extension is that most people experience periods of unemployment that are shorter than four months, except during severe recessions.

Still, as the accompanying table shows, a large proportion of those who have been unemployed for more than four months lose their insurance coverage and remain uncovered. They are also the ones more likely to experience the growing financial and emotional stresses associated with prolonged unemployment, and that makes continued and stable health insurance coverage all the more necessary for them.

Ideally, everyone would have unbroken health insurance coverage while unemployed. Short of that, I would favor a system that parallels current unemployment benefit arrangements, whereby a laid-off worker's health insurance would be continued at least as long as the worker's unemployment benefits. Payments for such a program could be made from a fund financed in much the same way as current unemployment benefits. This is not a novel idea; in several industries workers have won, through collective bargaining, supplementary unemployment benefits that include continued health insurance protection. While not ideal, modelling extended health care coverage on unemployment benefits will at least increase protection levels when the unemployment rate is high. During such periods unemployment benefits are provided for longer periods, and health insurance coverage would be similarly extended.

LIMITS ON OUT-OF-POCKET EXPENSES

H.R. 4742 would create statewide insurance pools and it stipulates that health coverage provided through such pools must limit the amount of annual out-of-pocket expenses for covered services to $1,500 under individual coverage and $3,000 under family coverage. If the intent of this requirement is to provide protection against out-of-pocket expenses that are financially catastrophic, the stipulation in its current form may achieve that goal only imperfectly.

A financially catastrophic expense is usually defined as an amount that exceeds a person's ability to pay. Therefore no single amount specifies the point at which expenses become catastrophic for all individuals or all families. For example, a $3,000 out-of-pocket expense represents 20% of family income for a family that earns $15,000 a year while it is only 5% of income for a family earning $60,000. For the first family, with relatively little disposable income, the $3,000 is likely to be a crushing financial burden, whereas it is a far more manageable expense for the second family.

Some state catastrophic health programs specify limits on out-of-pocket expenses that are related to income and other measures of ability to pay. On the other hand, private insurance policies usually do not specify limits in that manner. One reason is the greater administrative complexity of doing so. I also recognize that the incomes of those who are likely to seek insurance from a statewide insurance pool may not span a very broad range. Nevertheless, I would urge that the limits on out-of-pocket expenses be tied at least to income, if not to other measures of ability to pay, in order to provide more equitable and more meaningful protection against financially catastrophic expenses for a population that is likely to be particularly vulnerable to any large financial burden.

CONCLUDING COMMENTS

In 1983, at the height of a very severe recession, when all attention seemed to focus on the need for health insurance for the unemployed, there were those who tried to redirect some of this interest toward the millions of Americans, most of them employed, who have always lacked any kind of health insurance coverage. As the economic climate improved, most of the attention did shift, particularly at the state level, towards the medically indigent, the underinsured, and the employed uninsured, to the point that health insurance for the unemployed virtually disappeared from the agenda.

In my view H.R. 4742 strikes a good balance between the two orientations. It attempts to address the needs of the uninsured, particularly the uninsurable, while also attending to the needs of those who lose their health insurance as a result of unemployment. The approach it takes in the latter regard is the one most likely to not disrupt continuity of medical care, because it assures continuity of coverage. Nevertheless, the four-month limit on the extension of coverage leaves a large potential gap, particularly during recessionary periods, when more people are likely to be laid off for longer periods of time. But even in the best of times the need for continuing health insurance is particularly great among those who have been laid off for longer than four months. That need should be addressed, even recognizing the constraints reflected in H.R. 4742 to avoid burdening further the federal treasury. An approach modeled on unemployment benefits may prove financially feasible while affording better, if not ideal, protection.

Similarly, protection against financially catastrophic expenses for those insured through statewide insurance pools will be truly effective only if limits on out-of-pocket expenses are tied to income or other measures of ability to pay. This aspect deserves special attention given the higher probability that a person insured through such an insurance pool will have high health care expenditures and limited financial means.

HEALTH INSURANCE COVERAGE OF THE UNEMPLOYED BY DURATION OF UNEMPLOYMENT

	Duration of Unemployment in Months						
	<4 N=149	4-6 N=79	7-12 N=104	13-24 N=335	25-36 N=312	>36 N=348	All N=1327
Without Insurance	31%	49%	49%	49%	57%	56%	51%
Not Insured While Employed	14%	15%	14%	13%	10%	7%	11%
Lost Insurance	17%	34%	35%	36%	47%	49%	40%
Covered By Health Insurance	69%	51%	51%	51%	43%	44%	49%
Will Lose	30%	8%	10%	3%	.3%	1%	5%
Lost, Subsequently Obtained Other Insurance	9%	13%	18%	27%	22%	21%	21%
Still Had Employment-related Insurance	10%	10%	7%	3%	3%	4%	4%
Retained Insurance Unrelated to Own Employment	20%	20%	16%	18%	18%	18%	19%

STATEMENT OF

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Mr. Chairmen, it is a pleasure to appear before the Subcommittee on Health. My name is Gail Wilensky. I am the Vice-President of Health Affairs at Project HOPE. I am here today, however, not as a representative of Project HOPE but as a health policy analyst who strongly supports Section 5 of HR4742, "Health Care Improved Access Act of 1986."

The 1980s has been characterized as the period of the "prudent buyer." All of the major purchasers of health care--the federal government, state and local governments, and most importantly the private sector--have concentrated on paying only for what they buy and getting the best price for their purchase. The result has been a shift from implicit to explicit financing. Items such as uncompensated care which were once financed implicitly, that is by cost subsidy, have been placed at risk. While the list of items that used to be implicitly financed includes more than the care of the uninsured, the issues of the uninsured and of uncompensated care are the most visible problems of the change in the financial system.

Uncompensated Care Versus The Uninsured

We hear much about uncompensated care, the providers way of looking at the problem. Looking at it in these terms indicates that it is indeed not a trivial problem. In 1978, uncompensated hospital care was estimated to be between $4.2 billion and $5.2 billion. By 1982, it had grown to $6.2 billion, by 1983, $7.8 billion, and estimates for 1984 indicate that uncompensated hospital care reached $9.4 billion. While public hospitals and teaching hospitals, particularly urban teaching hospitals, have experienced disproportionately large amounts of uncompensated care, all hospitals can be expected to experience increased difficulty in handling the problems of the uninsured in an increasingly competitive environment.

The problem, however, is not just uncompensated care--who should pay for those receiving care who either do not or cannot pay for that care--but more broadly, the care of the uninsured in a competitive environment. Measures of uncompensated care understate the problem because they only measure the effect of those who have actually gained access to the system. All of those who, for some reason, are left out of the health care system, or who keep themselves out of the health care system because they lack financial resources, never generate uncompensated care and are therefore uncounted in measures of uncompensated care. Research has shown that the uninsured are not only vulnerable financially, but medically as well. The uninsured systematically use less medical care than the insured population, even when they are sick, and are less likely to seek care as well (Wilensky and Berk, 1982; Robert Wood Johnson Foundation, 1985).

Who Are The Uninsured?

There is some debate about the number of uninsured in 1984. The number of uninsured reported by the Survey of Income and Program Participation (SIPP) as of the second quarter 1984, was 30.4 million individuals (unpublished data, SIPP). The number of uninsured according to the Current Population Survey in 1984 as reported by the Urban Institute was approximately 35 million (Wall Street Journal, June 3, 1986). While that is a large discrepancy, the fact of the matter is that that it will become increasingly more difficult for the uninsured to obtain care in our current financial environment. It is a major problem for 30 million uninsured; it is an even more serious problem if there are 35 million uninsured.

The characteristics of the uninsured, particularly with respect to their employment status, have remained surprisingly consistent since the late 1970s (Monheit et al., 1984; Monheit et al., 1985; Urban Institute). Estimates of the uninsured who are employed at least part of the year have ranged from 45 to 55 percent of the uninsured population. Estimates of the employed uninsured and their dependents indicate that this group accounts for as much as 75 percent of the uninsured population. Furthermore, estimates indicate that almost 90 percent of the employed uninsured worked for firms who do not offer plans or are employees who are ineligible for the plans offered. These figures indicate that policies which make it more likely that the employed uninsured obtain insurance coverage could dramatically affect the number of uninsured in the population.

Although we do not know as much about why some small employers offer health insurance and others do not, we know that small firms are much less likely to offer health insurance than larger firms and that employees working for small firms are less likely to be insured than employees working for larger firms. According to a recent survey by the National Federation of Independent Businessmen, 32 percent of the firms with under four employees provided health insurance to all employees. Although the percentages varied slightly for firms with 5 employees to 100 employees, overall 50-60 percent of these firms provide health insurance to all their employees. The Small Business Administration has reported statistics which look at the problem in a slightly different way, that is, the percent of employees covered under health insurance for firms of varying sizes. They report that for firms with less than 25 employees, just under 40 percent of the employees are covered by health insurance, whereas for firms with 25 to 100 employees, approximately 65 percent of the employees are covered under health insurance (Dennis, 1985). This number increases to 75 percent for firms with 100 to 500 employees and over 85 percent for those firms with more than 500 employees. In any case, the message is clear: small firms are less likely to offer health insurance coverage and employees working for small firms are less likely to be covered under health insurance. There are several reasons cited by the NFIB study as to why small employers are less likely to offer health insurance coverage, such as the high cost of insurance and high turn over rates, but the inability of some firms to use pretax dollars to purchase health insurance is clearly one reason.

Tax Policy And The Employed Uninsured

As many on your subcommittee know, I have been one of several health policy analysts who have argued against unlimited tax excludability of health insurance premiums. But at the same time, there is little justification for not allowing certain segments of the employed population the same tax subsidies enjoyed by the rest of us. Under current tax law, the self-employed and the owners of unincorporated businesses cannot deduct the premiums for their own health insurance plans. This not only means that the self-employed and owners of unincorporated businesses are less likely to be covered by health insurance, but it also means that their employees are less likely to be covered as well.

Section 5 of HR4742 has several important provisions which would correct this problem. First, for purposes of qualified group health plans, self-employed individuals would be treated as employees. Second, half of the participants in the plan must be either employees who are not self-employed or employ family members of self-employed individuals. Third, the plan must benefit all employees not covered under another health plan. These provisions will both provide a greater incentive for the self-employed to purchase health insurance for themselves and will not permit the self-employed to purchase health insurance using pretax dollars only for themselves and not for their employees. Together these incentives should substantially increase the likelihood that the self-employed and their employees obtain health insurance coverage.

How Many Would Be Helped Under Section 5?

We cannot estimate with any precision how many of the employed uninsured are likely to obtain insurance coverage as a result of the Section 5 provisions. One reason is that we do not currently know how many workers who work for unincorporated businesses are not offered health insurance coverage. In fact, I have been unable to obtain the number of unincorporated businesses by firm size in terms of the number of employees. Estimates from the IRS Statistics of Income (see Table 1), however, indicate that 67 percent of unincorporated businesses had receipts of less than $25,000 and 91 percent had receipts less than $100,000. Only 1 percent of unincorporated businesses had receipts greater than $500,000. These statistics indicate that there can be little doubt that the vast majority of unincorporated businesses are small firms which independent statistics tell us are unlikely to offer health insurance coverage.

Conclusion

Allowing the self-employed and unincorporated businesses to deduct their own health insurance premiums will not help all of the employed uninsured. To the extent that many small employers do not offer health insurance because they face high labor turnover, they have large numbers of secondary workers, or because their employees do not want health insurance coverage, there will need to be specific strategies and solutions to deal with these particular problems. But to the extent that employers do not offer health insurance because they cannot use pretax dollars for their own coverage, this provision is an important contribution to increasing the health insurance coverage of the employed uninsured. If we as a society believe that federal tax policy should be used to promote and expand the coverage of private health insurance--and apparently we do--we should extend this benefit to those not now covered. By doing so, we will increase the likelihood that farmers, small shopkeepers and other owners of unincorporated businesses will obtain the health insurance coverage they and their workers so badly need.

Table 1

1983 IRS RETURNS OF UNINCORPORATED BUSINESSES
(NON-FARM SOLE PROPRIETORS)

RECEIPTS IN $	# OF BUSINESSES
Under $2,500	2,908,500
$2,501 to $5,000	1,313,600
$5,001 to $10,000	1,452,300
$10,001 to $25,000	1,916,600
$25,001 to $50,000	1,877,000
$50,001 to $100,000	919,300
$100,001 to $500,000	888,700
$500,001 to $1,000,000	82,900
+$1,000,000	34,900

SOURCE: SOI Bulletin, Department of Treasury, Volume V, #1, Summer 1985, Table 6.

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Chairman **Stark**. Dr. Wyszewianski, do you have any figures on the percent of covered employees, insured employees, who have an extension option?

Mr. **Wyszewianski**. I don't have those.

Chairman **Stark**. Do you have a guess? We have heard testimony that a large number of employers already include benefits that extend. I don't know whether any statistics exist. I was wondering if you know.

Mr. **Wyszewianski**. The only thing I can say on that subject that is grounded on something I know about is when we did our study, clearly a much larger number of people who had been unemployed more than 4 months had lost their health insurance as those who had not.

Chairman **Stark**. Losing it or not being able to pay for it?

Mr. **Wyszewianski**. We are talking about losing, they had it, and now they don't have it.

Chairman **Stark**. We don't know whether they could have converted at a higher rate?

Mr. **Wyszewianski**. We do, and some of them did convert. If you are talking about having lost insurance and having to get insurance through your spouse and so on, I include a table that summarizes that in my statement. You are talking about a difference, like 17 percent versus 34 percent.

Chairman **Stark**. Do you have any statistics on that as far as negotiated plans or what percentage of insured workers would have some extension already?

Mr. **Killeen**. We put some figures in our text, but we got them from the Department of Labor, which does gather information along these lines. One statistic which we got on our own and not from the Department of Labor was from Blue Cross-Blue Shield of Michigan. The percentage of people who lose group insurance coverage who convert to individual policies is only 1 percent out of—people who leave group coverage have an option to elect at their own cost individual policies. Only 1 percent have taken advantage of that in Michigan because of the cost of such policies.

Chairman **Stark**. What I can't quantify here is, I have heard from individual businesses who say we provide this for our employees, but I have no——

Ms. **Wilensky**. I don't remember the number by memory. The last statistics I know of were associated with the 1977 survey. My understanding is that there is a big dropoff for those who will offer an extension after 30 days but that my understanding is that large firms typically do offer——

Chairman **Stark**. Thirty days.

Ms. **Wilensky**. And the potential for shifting to individual coverage, but typically not at the employer's cost.

Chairman **Stark**. That is what I would guess.

Ms. **Wilensky**. That is my understanding.

Chairman **Stark**. Mr. Coyne.

Mr. **Coyne**. I have no questions.

Chairman **Stark**. Mr. Pickle.

Mr. **Pickle**. Just a matter of information, under the bill that is proposed, which would extend the coverage for 4 months, what would be the effective date of that time? Would that depend on passage of the bill?

Chairman STARK. When would this go into effect?

Mr. PICKLE. Yes.

Chairman STARK. January 1, 1987, I guess is in the bill.

Mr. PICKLE. January 1, 1987. Thank you.

Chairman STARK. I want to thank the panel. And, again, in response to Dr. Wyszewianski's comment, I think probably the committee would agree with you, there is a question of money. As someone on the earlier panel said, most of this is getting paid for one way or another, human suffering, bad debts or the community picking up the slack; I think we got a figure of something like $1.5 billion is the cost for 4 months if the Federal Government were going to pickup the whole thing. If you are going to go out much more than that, again depending on the economy, you could be talking about substantial funds to lay on the private sector.

We look forward to working with all of you as we try to see this legislation pass Congress. Thanks very much.

Our next panel consists of Aaron Trippler, national legislative public relations director, Communicating for Agriculture; Lou Zellner, deputy commissioner, State of Wisconsin, Department of Health and Social Services; H. Michael Shiffer, assistant vice president for government and industry relations, CIGNA, Health Insurance Association of America, accompanied by James A Dorsch, Washington counsel, HIAA; and John Burry, Jr., president, Blue Cross and Blue Shield Mutual of Northern Ohio.

I welcome you all to the committee—the general topic of this panel is risk pools—and ask if Mr. Trippler would like to lead off and summarize his testimony in a manner he is comfortable with.

STATEMENT OF AARON K. TRIPPLER, NATIONAL LEGISLATIVE PUBLIC RELATIONS DIRECTOR, COMMUNICATING FOR AGRICULTURE

Mr. TRIPPLER. Yes; my name is Aaron Trippler. I am national legislative public relations director for Communicating for Agriculture, located in Minnesota.

We are a national, nonprofit organization dedicated to the preservation of rural America. We are here for a couple of reasons. First I want to commend you for the opportunity to appear here today and to thank you for caring for people around the country unable to previously purchase health insurance due to preexisting health conditions.

The thrust of my testimony is going to be talking about the risk sharing pools. While we are interested in the rest of the legislation, this has always been our top priority since 1975 when we worked to establish one of the first State pools in the State of Minnesota. Today, the State of Minnesota has a pool which has been in existence since 1976 and has over 10,000 people using it at a cost of a little over $1 per person.

During the past several years we have attempted to assist all States in taking a look at risk sharing pools. During the last 3 years, we have assisted over 30 States with model legislation, analysis of projections for cost containment in that pool, how many people we think are going to use it, what we think the premiums charged would have to be, and a basic rundown on all the pools in existence. Over 30 States have requested this assistance. In the last 3 years, 20 States have seriously considered the issue.

In 1985, we were successful in passing the legislation in the States of Nebraska and Montana. These pools will become operational later this year. In 1986, we have been successful in passing it in Iowa and Tennessee. Basically, the approach they have taken is based on our legislation and modeled after the National Association of Insurance Commissioners legislation.

Chairman STARK. Which is the most highly industrialized State that has a pool?

Mr. TRIPPLER. I believe Indiana.

Right now the pool is in existence in 10 States. There are about three or four more considering it as of today. What I have learned in testifying in approximately 30 States in the last 3 years is there is one major concern out there. We must convince people that a risk sharing pool is not for everyone. This is intended for people who want to pay their own way, people such as in rural America, the group I represent, people who are self-employed and independent. All they are asking for is the opportunity to purchase insurance.

It is rather ironic in a country like ours that you can be one of the worst automobile drivers, yet you have the ability to buy automobile insurance. But perhaps because of a condition since birth, you may not be able to purchase health insurance.

When we testify and provide facts and figures to States around the country, we keep hearing the one obstacle to creating more State pools, and that is the whole idea of not including self-insurers as members of the pool. I actually have a little sympathy for some of the insurance companies, because it is an unfair burden to them. Why should they be the only people who have to contribute to a pool? Yet in most States, the States provide them a credit on their premium taxes for assessments.

What we are saying is we really believe the States want to solve this problem on their own, they want to take care of their citizens. but Government was really created to handle those problems we cannot handle ourselves, and that is why I think your proposal is perfect. I think the concept of amending the law so self-insurers will be members of a pool will cause more States, especially California——

Mr. PICKLE. How about Texas?

Mr. TRIPPLER. Texas introduced it a couple of years ago, but not since then. I believe if we could change something like this, the States will implement State pools. The provisions in this bill on the premium caps, the waiting periods, the maximum lifetime benefits, they are all what we would consider perfect recommendations. Many States have taken a look at different options available through pools. Today, in the States using pools, over 20,000-plus people are covered. That doesn't mean to say we can't increase the base and add more people across the country. But right now they are working, and if we can change the self-insurance obstacle, perhaps we can stabilize the premium cost, and expand the base.

I believe when the individual from Wisconsin talks, they might tell you about some of the things they are doing. All in all, what Communicating for Agriculture has attempted to do is become a clearing house on this information, to provide States with recommendations on what is working and what isn't working around the country. We have found CA to be a very, very positive effect out there in the country because many States are seriously taking a look at it.

I think one concern which has been overlooked is that rural America falls into the cracks when it comes to health insurance. We don't have an opportunity to buy group health plans, such as employer-employee type. We must go through underwriting, answer health questions, and take physicals. It isn't fair we don't have the opportunity to purchase health insurance, and there are millions of people across the country with chronic diseases in the same predicament.

I would recommend that you do pass this legislation, let the States take a look at it. Let them attempt to pass and operate their own pools. We just need a little push from you. That is what we are hoping to do. CA has been around only nationally since 1977, we have been involved in this issue in over 30 States, and we offer our assistance to you, the committee, and the panel in any efforts.

Thank you very much for this opportunity, and, of course, I will answer any questions at the conclusion.

Chairman **Stark**. Thank you very much.

Lou Zellner from the State of Wisconsin.

STATEMENT OF LOU TURNER ZELLNER, DEPUTY INSURANCE COMMISSIONER, STATE OF WISCONSIN, OFFICE OF THE COMMISSIONER OF INSURANCE

Ms. **Zellner**. Thank you.

My name is Lou Zellner, and I am appearing as the deputy insurance commissioner for the State of Wisconsin. I am also the Chair of Wisconsin's Health Insurance Risk Sharing Plan [HIRSP] for medically at-risk individuals. I will limit my testimony to section 2 of the bill on the incentives for the establishment of statewide insurance pools.

In 1981, the State of Wisconsin established a health insurance plan for medically at-risk individuals. As a State we have made a significant commitment to assuring that Wisconsin residents are not denied access to health insurance because of their poor health. I believe that you, Chairman Stark and Representative Gradison, as well as your Senate colleagues, are to be commended for your commitment to this public policy goal.

I have attempted to review the bill with three main questions in mind: First, how does the bill attempt to assure access to health insurance for the medically at-risk? Second, what does the bill say about the affordability of such coverage for the individual? Third, how does the bill address sources of funding for these efforts?

My brief review indicates the following. The bill assures access by mandating that each State establish a health insurance pool of a particular type. While this approach may accomplish the authors' intent, I believe it causes needless difficulties for States by limiting their options. For example, in Wisconsin, our plan is limited to high-risk individuals. Although Wisconsin has made a significant commitment to this program, our plan would not comply with the standards in section 2 for this reason alone. Several other States also take this approach. If Wisconsin's plan did not come into compliance, the State could lose substantial Federal dollars—including some funds supporting Medicaid.

Some States take other approaches. For example, there is no pool, but access is provided by a health carrier agreeing to hold periodic open enrollments during which coverage is offered without regard to health status. In one State there is a pool, but both the healthy and the sick may enroll.

I would strongly urge that the committee amend H.R. 4742 to allow this diversity to continue. An approach that works in Connecticut or California may not work in Wisconsin; and one that works in Wisconsin may not work in Texas, Ohio, or New York. The goal after all is to make sure each State does something that works.

H.R. 4742 also recognizes that because the cost of insuring high-risk individuals is significantly higher than for standard risks, it is important to reduce the price high-risk individuals pay for coverage below the actual cost. I suspect this is based on the belief—which I share—that individuals should not be severely penalized financially for their ill health. But for the roll of the dice, it could have been you or me, rather than the other guy.

The bill suggests at least three ways to deal with this special affordability problem: one, pooling high-risk people with some group of standard risks; two, providing income sensitive premium subsidies; and, three, providing an across-the-board subsidy funded by insurers and self-funded employers.

It should be possible to combine these three strategies in different ways to achieve the objective of making insurance more affordable for high-risk individuals. Yet, the bill, as drafted, would mandate the first approach—pooling high-risk individuals with standard risks. It would allow income based premium subsidies and across-the-board subsidies. I would urge the subcommittee to give States the flexibility to combine these three approaches in ways that best suit their individual needs.

In Wisconsin, we have chosen to have a separate pool for the high-risk individuals. A subsidy is provided all of these individuals by assessment of health insurers—and initially of self-funded employers. We also provide a premium subsidy based on income funded out of general purpose tax revenues.

Chairman STARK. Who is eligible other than income for the premium subsidies, poor people, not just ones who have—high-risk/low-income?

Ms. ZELLNER. That is correct.

Persons who are HIRSP policyholders and who have family incomes of up to $16,500 are eligible. Those who come from the poorest families will have their premium reduced from 150 percent of a standard risk to 100 percent of a standard risk. Because we do not view this program as an income maintenance program, we seek only to offset the extra cost associated with the individual's poor health. At present, 30 percent of our plan's policyholders receive some premium subsidy. I feel the bill should be amended so that approaches such as this are acceptable rather than requiring a pooling with standard health risks. At present, the plan board is reviewing the adequacy of the premium subsidy and considering whether changes in plan benefits are needed. If the bill were passed, many of these efforts would have to be put aside, and the mandated program structure put in place.

The final comment I would make relates to the assessability of self-insured plans. I believe the broadest possible group of people should help to subsidize coverage for high-risk individuals. As many of you probably know, Wisconsin law originally authorized the assessment of both insurers and self-funded employers. Because the State law was successfully challenged in court by self-funded employers subject to ERISA, the current deficits in the plan are funded entirely by insurers and their policyholders. This bill provides a strong incentive for self-funded employers to participate in State programs for the medically at-risk. I feel this is the single most important feature of section 2 of the bill. This change alone should provide many States with the needed incentive to tackle this problem.

In conclusion, I would again like to thank you for the opportunity to appear today. In summary, I would state three things: One, it is important that the medically at-risk have access to health insurance. For this reason, I support the purpose of section 2.

Two, the ability of the States to pursue this goal and their willingness to support this legislation will be greatly enhanced by providing flexibility on the approaches States may take to assure such access.

Three, the enactment of a strong incentive for self-funded employers to contribute financially to State efforts is a significant improvement. This change should make it easier for States to fund programs for the medically at-risk.

Chairman STARK. Thank you.

Mr. Schiffer.

STATEMENT OF H. MICHAEL SCHIFFER, ASSISTANT VICE PRESIDENT FOR GOVERNMENT AND CIVIC AFFAIRS, CIGNA CORP., REPRESENTING THE HEALTH INSURANCE ASSOCIATION OF AMERICA, ACCOMPANIED BY JAMES A. DORSCH, WASHINGTON COUNSEL

Mr. SCHIFFER. Thank you. I'm Michael Schiffer, assistant vice president of CIGNA. I'm here representing the Health Insurance Association of America, comprised of 335 companies which write about 85 percent of the private commercial health insurance. We have been, as you know, strong supporters of this kind of legislation since the late 1960's. We certainly want to commend you, Mrs. Kennelly, and other members of the committee for your drafting of this legislation, and we want to assure you that we are prepared to work with you in its passage. We think the time to do that is now.

A number of consumer organization who have joined the HIAA in support of this proposal for State pools for the uninsurables, and represent many of the most vulnerable individuals in our society today, such as the handicapped and those with hereditary diseases.

We also frequently found, at least in Connecticut, that people who lose employment use this mechanism as a way to obtain health insurance coverage. It provides a means at the time people need it most for them to get health insurance.

I should point out before I continue that really we are dealing with a small portion of the population. We estimate that between one half and 1 percent of the total population of the United States is not able to get health insurance because of poor health. We do cover many, many uninsurable people through the group insurance mechanism, and they, therefore, have that kind of access. We estimate, again, that close to 180 million people are covered under group insurance in this country. That is a substantial number.

Of course, it is little solace for the people who cannot get insurance, and for that reason we feel your legislation deserves careful consideration. It has been our belief that the national goal of having everybody have access to adequate health care in this country is one that needs to be pursued and be pursued very vigorously. The key, as has been mentioned twice—and I have to thank my colleagues; this was not rehearsed—the key to making this work is having the risk spread as broadly as possible. And that suggests you don't want to disturb the competitive marketplace that is out there.

Unless we solve this problem of ERISA and the lack of participation by certain financing entities, we are not going to have reinsurance pools enacted in the States, and we are not going to be out there favoring them. The problem is you have a shrinking number of people covered by traditional insurance programs and they tend to be smaller employers or individuals.

So the people least able to afford to subsidize the pools are being asked to subsidize them under the current arrangement. Therefore, we are very, very enthusiastic about the idea of using the legislation in the way in which you have designed it, so that all financing agencies will, in fact, participate.

Mr. Trippler mentioned the cost of the subsidy is not expensive. We estimate, as he does, a little over a dollar in Minnesota. In Connecticut it tends to be less than that per capita, about 50 cents per person for the subsidy itself. When that is spread over a large base of people, I think there is very little complaint that people ought to offer.

I have to do a little one-upmanship. Actually, the Connecticut pool was the first one that was instituted in the country. We started in 1975. It was at the urging of the insurance companies at that time that the pool was begun. So we take some pride in that. And we did in fact at that time pass the law to require all financing mechanisms to contribute. It was as a result of a court case that we found that in fact assessing self-insurers was tantamount to taxation, and taxation was tantamount to regulation, and therefore the whole thing got dissipated, and we have been carrying the burden ever since.

Now, the taxing incentives in the bill assure there will be broad participation by employers in the pool. No Federal revenue will be raised as a result of this. The financing essentially comes from the private sector where we think it ought to be. And we certainly endorse the notion of allowing the States some flexibility to do their own regulation.

With your permission, if I have just a couple more seconds, I would like to just comment on a couple other portions of the bill.

Chairman **Stark**. Please.

Mr. **Schiffer**. We strongly support the notion of additional tax incentives for the small employer and individuals. We know it is a substantial problem and whatever help you can give through the concepts in the bill certainly makes a lot of sense.

With respect to the continuation of insurance, we I think are solidly on the fence on that one. There is no question that——

Chairman **Stark**. Have you done anything on costs? You insure some huge corporations. I would appreciate it if you could provide some cost data. People that don't want to pay for it say it will cost $1 billion a year. If we do it, you are going to have to sell it.

[The prepared statement and a letter subsequently received follow:]

STATEMENT

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA

Good Morning, Mr. Chairman, and Members of the Subcommittee. I am Michael Schiffer, Assistant Vice President of Government and Civic Affairs for CIGNA Corporation and Secretary of the Connecticut Reinsurance Association, Connecticut's High Risk Pool.

I appear before the Subcommittee today on behalf of the Health Insurance Association of America. The HIAA is a national trade association comprised of 335 companies which underwrite or administer approximately 85% of the private commercial health coverage in this country. I am accompanied by James A. Dorsch, Washington Counsel for the HIAA.

We appreciate this opportunity to comment on proposals to make health insurance available for persons considered uninsurable due to poor health. We particularly commend you, Chairman Stark, and Ways and Means members Kennelly, Gradison, Rangel and Matsui for your sponsorship of Federal legislation on this issue, H.R. 4742 and H.R. 1770. With your leadership, we can make private health coverage available to those Americans who might otherwise be denied insurance because of poor health.

The HIAA fully supports legislation to encourage states to establish voluntary risk pools for uninsurables. The commercial health insurance industry has actively supported such a measure since the late 1960's as a key building block in efforts to bridge existing gaps in coverage. Now is the time to make this concept a reality.

Joining the HIAA in its support of state risk pools for uninsurables are more than 3 dozen national organizations representing millions of this country's most vulnerable citizens--the sick, handicapped, and elderly. Together we recognize that in many cases those unable to obtain health coverage are working people who are willing and able to pay for insurance but are unable to obtain it because of poor health. In other cases, they are older people who, upon leaving their employment, find they cannot purchase individual coverage. At the time they need health insurance most, they are left without it. The inability to obtain adequate insurance has serious consequences not only for these individuals but for their families as well.

Before continuing, I should point out that the concern here is focused on a relatively small fraction of the population, and that the vast majority of working Americans are already covered by health insurance. The HIAA estimates that at the end of 1983, approximately 176 million persons under age 65, including spouses and children, were covered by one or more forms of private health protection. Eighty-five percent are covered by employee group insurance, usually without individual medical underwriting. About fifteen percent are covered by individual health insurance policies. These individual policies will generally continue coverage for persons with health problems once purchased, but in accordance with general insurance principles must have been purchased while the buyer was in good health. Thus, some individuals, such as those not eligible for group or group conversion coverage and those never having been in good health, may fall between the cracks.

The fact that the great majority of Americans do have some type of insurance coverage, however, provides little comfort to those who must go without. The HIAA feels that universal private health coverage for all employees and their dependents is an important national social goal; in this vein, we see no reason not to cover everyone who's willing to pay. Thus state high risk pools are designed to be the insurer of last resort for individuals who want health insurance protection and currently can't get it in today's health insurance market place.

State high risk pools work by spreading the excess financial risk of covering otherwise uninsurable individuals among all health insurance plans in the state, including self-insured businesses. The risk pools set a ceiling on the premium charged which, when combined with the health status of the persons in the pool, can generally be expected to produce pool losses. The key to effective operation of the pools is to assure that these losses are spread proportionately among all the competitors in the health insurance market place. They do not represent a great financial burden on any one insurer if financed by adequate premiums and if the losses are spread equitably over the entire insured population.

For example, in 1985 the losses of the Minnesota state pool were approximately $5 million. If spread over all insured lives under age 65 in Minnesota, including all protected employees and their dependents, losses would be approximately $1.40 per person per year. In Connecticut, 1985 losses were approximately $1.5 million or $.50 per person.

Eleven states currently have some form of health insurance pool for uninsurables: Connecticut, Florida, Indiana, Iowa, Minnesota, Montana, Nebraska, North Dakota, Rhode Island, Tennessee, and Wisconsin. In 1975, the HIAA supported the creation of the first state risk pool in Connecticut. Because of the this pool, there are now no uninsurables in Connecticut. Under the Connecticut law, the losses of the pool were to be shared among all the competitors in the health insurance market place -- the commercial insurers, Blue Cross/Blue Shield, HMO's, and self-insured employers -- on a pro-rata basis. Thus, the high-risk individuals received coverage but the competitive market place was not upset.

Subsequent court interpretation of the 1974 Employees Retirement Income Security Act (ERISA), however, which precludes the states from regulating employee benefit plans, means self-insured employers need not share in any pool losses. As more and more large employers self-insure, the burden of pool losses falls harder and harder on an ever decreasing base, principally small employers and individual purchasers of health insurance policies, who are already paying higher costs for their health protection.

The state risk pool provision of H.R. 4742, the Stark/Gradison bill, and H.R. 1770, the Kennelly bill, provides a powerful incentive for all states to establish risk pools by levying a 10 percent excise tax on employers, including self-insured employers, that do not participate in qualified pools. Because employers will find it much less costly to participate in the pool, there will be no revenues from the tax. Instead, the actual financing of the pools will come from the private sector. The design and operation of the insurance pools will be at the discretion of each state, and they will be regulated by the state like any other insurance product. The HIAA endorses all of these concepts.

We should stress that the state risk pool proposal would not require a single dollar in Federal revenue. Mr. Chairman, when you consider this in light of the fact that industry and consumers are joined in support of a measure to solve the health care needs of Americans currently left out of our private health insurance system, we see little reason why the measure should not be swiftly approved by Congress.

The HIAA believes that this legislation is a creative solution to a growing problem. While it does not resolve the health care problems of the poor, it will prevent many Americans from being forced into poverty and onto Medicaid by catastrophic medical bills.

It will help ameliorate hospitals' growing bad debt and uncompensated care problems, thus making more funds available for the truly needy.

Mr. Chairman, with your permission, I would like to comment very briefly on the other major sections of the Health Care Improved Access Act. Our industry certainly endorses the concept of providing tax incentives to individuals and small business people to purchase health insurance for themselves and their employees. However, the concept of requiring employers to continue payment for health insurance coverage for terminated employees for a period of 4 months requires thoughtful consideration. Health insurance in America is provided primarily through employment based coverage. Consequently, any requirement to continue coverage for a temporary period certainly has merit. We are, however, concerned about the possible counter-cyclical impact of the requirement to make employers responsible for payment. Frequently, this requirement would come into effect at a time when an employer, and particularly a smaller employer, may be least able to afford the extra burden of covering terminated employees. It is quite possible, that with some additional changes in the tax law, pre-funding of these kinds of benefits may be feasible. However, we would like to reserve judgment and suggest continued study of this aspect of the proposal to carefully consider all of the economic implications.

As you know, we are currently implementing the Federal Continuation of Benefits provisions of the Comprehensive Omnibus Budget Reconciliation Act of 1986. The superimposition of Federal requirements on existing state legislation is causing an immense amount of confusion, not only for our insured employers, but for the Federal drafters of regulations as well. It will be important in this piece of legislation and other Federal legislation that impose insurance requirements on employers, to consider carefully the interaction of Federal laws with state laws and to override state laws, if necessary. We have discussed this issue with you in the past, and are prepared to renew this discussion with you and your staff.

Finally, we are firmly convinced that as the American health care system moves to a more competitive approach, the issue of uncompensated care must be dealt with decisively. States pools that redistribute hospital revenues to needy institutions have been established in 5 states and seem to be working. I would point out, however, that I am aware of at least 15 responsible national trade associations and consulting firms that are examining broad-based solutions to the problems of funding uncompensated care.

I believe there is universal agreement that the solution must be a broad-based partnership between government and the private sector, and I am sure that given just a little more time and study, the right answers will emerge. We would prefer more definitive instructions to the states, rather than the somewhat open-ended approach described in this legislation.

In conclusion, we believe the risk-pool provisions of the Stark/Gradison and Kennelly bills will ensure the availability of health insurance for all Americans, regardless of the condition of their health, with an absolute minimum of Federal regulation, and at no cost to the Federal treasury. The Health insurance Association of America stands ready to assist you, Mr. Chairman, and members of the Subcommittee, in securing enactment in Congress of this important health care measure.

A copy of the statement of the Coalition for Health Insurance Availability is attached for the record. Thank You.

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H. Michael Schiffer
Assistant Vice President
Government & Industry Relations

CIGNA

June 17, 1986

Brian Biles, M.D.
Chief of Staff
Committee on Ways and Means
Subcommittee on Health
1114 Longworth House Office Building
Washington, DC 20515

Dear Brian:

I have had an opportunity to review the methodolgy used by CBO to estimate the cost of continuation of health insurance coverage to laid-off employees. While I am trying to get a better fix on the prevailing level of continuation benefits, my initial assessment is that the costs are considerably overstated. The basic reason for this is simply that the CBO methodology assumes that employers currently provide no continued action of coverage. In fact, almost all insurance contracts provide continuation of coverage for an individual who is disabled at the time of termination, at least until the end of the period of disability or twelve months, whichever is earlier. Beyond that, many of the major union contracts provide for extension of benefits far in excessive of four months. Benefits are frequently continued for up to two years, and certainly six months and one year are not unusual. The prevalence of two worker families, the incidence of displaced employees opting into their spouses' plan or spouses not requiring continuation of coverage because they already are covered under their own plan, is quite high. If we can get a better handle on the actual prevailing continuation provisions, we will provide you with additional information.

I also had some trouble with the assumption that employers would decrease benefits or reduce wages to compensate for a continuation mandate. I think the far more likely response would be for employers to simply increase prices. The fact that employee benefits were designed to attract and keep workers is sometimes lost in this day and age of cost containment. However, in a period of relatively low employment, fringe benefits continue to be an important competitive unemployment item and benefit reductions or lower wages are not a real threat.

Finally, I do have some concerns about the fact that the additional costs to employers would be incurred at a time when they are least likely to be able to afford the added benefit costs. The way to overcome this problem is to plan for it in advance. And, the way to plan for it in advance is to accumulate adequate reserves. DEFRA imposed rather tight limits on the "safe harbor" limits on reserves. If the continuation provisions are to be enacted, we would strongly suggest that the safe habor limit be adjusted upward.

Please let me know if we can provide you with additional information.

Sincerely,

Mike

H. Michael Schiffer
Assistant Vice President

Mr. **Schiffer**. We haven't done any costing figures lately, but I think we would offer on behalf of the association to do those numbers. We did some in the past. I think one of your staff people, Mr. Kern, will attest to the fact we spent a lot of time on that subject in the past.

Our ambivalence is based on this. Certainly as a piece of social legislation, as long as this country is going to have a system where most health insurance is provided through an employment base, some continuation of coverage is certainly necessary and desirable. The concern that we have is that if you ask the employers to pay for this, in all likelihood it will come at a time when they are least able to afford to pay for it.

So, economically, it could be countercyclical. There may be some ways around that, there may be some ways through changes in the tax law to do pre-funding of that. Our concern with the retired reserve limitations is that we cannot establish reserves for retirement——

Chairman **Stark**. Do you buy the concept that the net cost to a community—and I know that's hard to define—stays close to you, so that in effect, given this program going long enough, that the money you save in providing medical care is somewhat less because you don't have indigent costs loaded on when there is a major layoff? Is there any validity in trying to follow that string to the end?

Mr. **Schiffer**. There is a lot of logic to it. I think it is a valid argument. You are going to have trouble selling it politically to a large portion of the employer base, and I think you will hear later about that. Particularly the small employer. That's the big concern.

Chairman **Stark**. I want to make them feel better if they lose, that is all.

Mr. **Schiffer**. What we are urging, I guess, is that the economic implications be closely looked at and if there is some way to get around those and to solve that problem, I think you may have a viable concept there.

I guess the final point I would want to make is that we have been struggling, as you know, with the implementation of the Federal continuation requirements in the Comprehensive Omnibus Budget Reconciliation Act of 1986 [COBRA]. What we have found is that the superimposition of Federal laws on a myriad of State legislation has caused a fair amount of confusion for insurers, policyholders and even the people who are drafting the regulations here in Washington.

To the extent that this legislation would impose new requirements, I certainly think that we ought to revisit the question of whether any override of some of the State regulations and laws is appropriate or whether it is not appropriate.

Chairman **Stark**. It is my understanding we are beginning meetings with Treasury and Labor now and would welcome any input from your industry with an idea of some technical corrections, as we like to call them, in the reconciliation bill. We are aware of some problems that we created, and we will try to straighten them out. So you will be of some help to us there.

Mr. **Schiffer**. We will be more than happy to help.

Chairman **Stark**. The insurance industry is unregulated at the Federal level, and that is why we have tried to put incentives in rather than write regulations, because you have to have 50 sets of regulations.

Mr. **Schiffer**. We are not arguing for Federal regulations, sir.

Chairman **Stark**. I didn't think you were.

Mr. **Schiffer**. We will see what we can do.

We didn't mention the uncompensated care pools. We know pools are operating in five States and we think they are operating reasonably effectively. On the other hand, I am aware of at least 15 different organizations in this town, responsible trade organizations, who are really struggling with the issue of how do you get the right answer, how do you get the proper partnership with Government to solve this issue.

And while we strongly endorse the notion of uncompensated care pools, we are a little concerned about the broad kind of nondirective, open-ended instructions to the States to solve the problem without some more research, some more studies, some more guidance to solve that problem.

We are, I guess, nervous about a patchwork of legislation springing up at the State level.

Chairman **Stark**. If we could give that to Minnesota, Wisconsin, and Connecticut, we would come out all right, wouldn't we? And Texas?

Mr. **Schiffer**. We are not going to play unless Texas comes in.

Mr. **Pickle**. Is this Mr. Schiffer?

I didn't hear the first part of your dialog, but is it your position you think we ought to pass this bill, but you do not want to give the 4-month extension to terminated people; you want to give it to everybody else but not terminated people for 4 months. Is that correct?

Mr. **Schiffer**. No; that is not the correct position. We are strongly in favor of the risk pools as included in the bill. We are still looking very closely at the question of the extension of benefits to terminated employees, because we realize while it is good social legislation, it has potentially some negative economic impacts.

Mr. **Pickle**. You don't oppose 4 months but you have serious reservations about it?

Mr. **Schiffer**. I guess that would be an adequate representation of our position.

Again, we thank you for the opportunity, Mr. Stark, and we certainly strongly endorse the risk pool concept. We will work with you on this or any section of the bill where we can be very helpful.

Chairman **Stark**. Thank you.

Mr. Burry.

STATEMENT OF JOHN BURRY, JR., PRESIDENT AND CHIEF EXECUTIVE OFFICER, BLUE CROSS & BLUE SHIELD MUTUAL OF NORTHERN OHIO (CLEVELAND)

Mr. **Burry**. Thank you, Mr. Chairman, for allowing me to participate today. My name is Jack Burry and I'm president and chief executive officer of Blue Cross & Blue Shield of Northern Ohio. My company is the ninth largest Blue Cross plan in the country and we insure more than 1.7 million people. More than 500 companies are licensed to sell insurance in Ohio, including two other completely independent Blue Cross plans.

For the past 52 years, our Cleveland Blue Cross plan has insured all people, regardless of their health status—no age rating, 12-months open enrollment.

Chairman **Stark**. Go through that one again slowly.

Mr. **Burry**. For the past 52 years, our Cleveland Blue Cross plan has insured all people, regardless of their health status—no age rating, 12-months open enrollment.

Chairman **Stark**. You can come in and out any time? I can get cancer, move to Cleveland and sign up?

Mr. **Burry**. Unfortunately, we are suffering from that today.

Even though all the other Blue Cross plans many years ago joined all the commercial companies in Ohio in medically underwriting people not covered in merit-rated pools, we stuck to our policy.

So, having become the only Ohio company with an open door policy, we were in effect the insurer of last resort.

Chairman **Stark**. Are there others in the country or are you the last one in the country?

Mr. **Burry**. There are others in the country.

As such, our competitors soon adopted the policy of sending us the people they didn't want to insure.

The State department of insurance, which regulates our industry, not only allowed this competitively unfair situation to exist, but they refused our requests for rate increases for that market segment which contained the vast majority of people with hard to insure medical problems.

Rate hikes were denied because the insurance director said Blue Cross wasn't doing enough to control hospital costs—a State-mandated Blue Cross responsibility.

So, last year we became the first plan in the Nation to ask all hospitals to bid for our business. The program saved our customers more than $35 million. But then the courts intervened and ruled that the program violated State law, which they said required that we must contract with all hospitals.

In Ohio, we have State government saying we must control hospital costs, but also that we can't say no to hospitals at the bargaining table. Then the State denies rate increases because they believe we aren't controlling costs. This catch-22 situation makes it impossible for us to also continue as the only company willing to absorb the losses that result from insuring high-risk people.

Because Medicare covers people over age 65, the high-risk problem is with those people between the ages of 18 and 64 who are not covered by group insurance.

Last year, the 1,000 most costly non-group, 18 to 64-year-old subscribers we cover, accounted for $18.5 million in medical bills. Since 1980, we have sustained losses in excess of $40 million providing non-group coverage to these individuals with serious medical problems.

And since 1975, our losses for people of all ages in the non-group category have exceeded $120 million.

A recent survey showed we pay more non-group claims—54 percent—than all the other 500 insurance companies licensed to sell in our area combined.

Currently, we have enrolled between 5,000 and 10,000 individuals who would not have qualified for health coverage from any other insurer.

To be able to continue insuring these people, and to stop a financial drain that threatens our viability in the marketplace, we have decided, with great reluctance, to also begin health screening.

For as long as possible, we were a company that practiced what we preached—our firm belief that nobody should be denied health insurance. Unfortunately, now that we have been forced to become part of the problem, no one is left in our State to help these people. That disturbs me greatly.

On behalf of all those who need and deserve to be protected from the financial ravages that medical costs can inflict, we urge you to continue your efforts to provide fairly priced, affordable coverage to medically vulnerable people in America, by mandating that States solve the problem. In that process, you must of course equitably address the ERISA issue here in Washington.

I have not commented on the particulars of the bill before you. I am here to support your efforts, to thank you for caring, and urge passage of the bill. Thank you.

Chairman STARK. Thank you very much. How many States would you say there are in which coverage like yours is available?

Mr. BURRY. I am not aware of how many. I can tell you this, I was the chief financial officer in three other plans before coming to Ohio, New Hampshire, Vermont, Virginia plan and Michigan, and all three of those plans, when I was there over a period of years, all three had open enrollment and no health screening.

Chairman STARK. The costs are very much different from, say, your neighboring competitors who don't do it? I mean, can you get an empirical cost for exactly what that policy——

Mr. BURRY. No question about that. It has been said here earlier, there are a very small number of people on a percentage basis that are in this predicament but their health care costs are so catastrophic that no one segment of the community can possibly afford it, and of course the people themselves can't.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. Does that complete the panel?

Chairman STARK. Yes; I don't think we have left anybody out.

Mr. PICKLE. Let me ask the panel in a general sense. As I understand it, there are about 9 States which have these risk pools, and as many as 10 to 15 more are considering it. So we have some experience now, and I assume the risk pools have been underway for, what, 5, 10 years? Longer or shorter? What is the average period of time it has been underway?

Mr. SCHIFFER. The average has to be less. I think Minnesota and Connecticut were out there by themselves for a substantial period of time and most of the legislation is really in the last 2 or 3 years.

Mr. TRIPPLER. I believe after Minnesota and Connecticut, the others went in from 1981 to 1983. We passed four in the last 2 years but they aren't in operation yet.

Mr. PICKLE. We have about 3 plus or minus, years' experience to judge these programs, a little bit more, a little bit less. Does each State set its own premium?

Mr. SCHIFFER. Yes, sir.

Mr. PICKLE. Are they generally about the same?

Mr. TRIPPLER. Most run between 25 and 50 percent higher than standard risk rates in that State.

Mr. PICKLE. So the premium most of them have is higher than the regular or standard rate?

Mr. TRIPPLER. The minimum is 25 percent and the maximum is about 50 percent.

Mr. PICKLE. Wouldn't the premium be in the same range from State to State, or would it vary that much? How much variance is there between the States?

Mr. SCHIFFER. First of all, you will get variance between the States because of different levels of medical care costs between the various States. But beyond that, there are different screening mechanisms that are used by different reinsurance pools or high-risk pools to get people in.

In Minnesota, for example, I understand you have to be rejected by two insurers before you are eligible for the pool. In Connecticut, essentially anybody can come in and sign. To the extent that the Minnesota pool is guaranteed a higher risk person than Connecticut, the rates are going to be higher in Minnesota than Connecticut.

Mr. PICKLE. I have been shown a chart that shows most of the rates are from 130 to 150 percent. That gives us an average. Now, what experience have you had on the premiums? Have the premiums gone up? And how much have they gone up?

Ms. ZELLNER. When our plan was originally started in 1981, it was hoped the plan would be self-supporting within 3 years, and at that time we were setting premiums at 130 percent of the standard risk. Rates were increasing due to the increase in costs of medical care at roughly 15 percent per year during that time period. However, at the end of the 3 years we found the plan could not be self-supporting.

We faced a quandary of do we continue the subsidy the insurers are paying to the plan and continue the plan, or do we have a 370-percent increase in the premium rate, which would mean on paper we would have a plan but nobody in it. It was at that point we chose to go to the 150 percent of the standard risk for the premium charges, so there was a very significant increase in the premium cost at that time.

Mr. PICKLE. Am I correct in saying that in all the instances that the premiums have gone up, it will vary 10 to 15 percent per year; is that correct?

Mr. TRIPPLER. The way most of the State plans are set up, pool premiums are based on the average premiums charged by the five largest insurance companies in that State. These average premiums are then raised by approximately 25 to 50 percent. So, yes, the premiums are going to go up, but sometimes they are going up because the largest five insurers in the State have raised their premiums which raise the average in the State.

Mr. PICKLE. Of course you have to have a formula, a means to establish a premium. But I am just trying to find out how it works. I assume we have to say you set your own rates, they are higher, and that the premiums have gone up. One of the gentlemen said he believed if we had this bill, that the premiums would go down. I don't know how that could be. All of you are shaking your heads no, but somebody said that.

Mr. TRIPPLER. I said that, Mr. Pickle. I believe the premiums would go down or at least stabilize. I think the States would keep from raising the premiums as high as they must raise them now. If you are spreading the risk to more companies, the income level will increase, and I believe the States will write off a portion of that cost. They are not going to make it self-supporting.

Mr. PICKLE. I am going to ask you, how would the States keep the premiums down?

Mr. BURRY. The States are subsidizing it now. I believe they will continue to subsidize it.

Ms. ZELLNER. If I might, in addition to an across-the-board subsidy where we assess insurers, we have an income-based subsidy for low-income individuals. If you are concerned about the low-income individuals who are in these programs that can't afford to pay the premium, that is another option. We have just begun to do that, and about 30 percent of our people get that extra income-based subsidy.

Mr. PICKLE. Let me ask you a general question. In those States where you have the programs, what kind of coverage do they provide? Do they give the same coverage as any other insured person? Are they given the same kind of treatment? Is there any kind of limitation? Are their benefits the same as any other insured individual?

Mr. SCHIFFER. In Connecticut, yes. The benefits are essentially the same. It is broad comprehensive coverage including coverage for mental health, drugs, and things of that sort. The individual has the option of a $400, $1,000, or $1,500 deductible. Obviously, the price goes down significantly if he chooses the higher deductible. As provided for in H.R. 4742, there is a preexisting condition limitation of 6 months. And that is absolutely essential. Otherwise, you would have people coming into the program the day before they went into the hospital, and there is a requirement if this is going to be a reasonable——

Mr. PICKLE. If they are given the same kind of coverage, get paid whatever category of coverage, the same as anybody else, and since they are an at-risk case, poor risk to start with and had coverage before, then it would follow the payments to them are going to be greater, would it not?

Mr. SCHIFFER. Absolutely.

Mr. PICKLE. That means the premium is going to rise unless the mass approach, as the first gentleman said, might happen. So I think we have to recognize that that's a problem. I don't say that's good or bad, but it is a problem.

Let me ask you one other question. Is there any kind of a cap or limitation as to the amount an employer would have to pay?

Mr. SCHIFFER. The cap in the Connecticut arrangement is really on the total premium that the pool is allowed to charge the person enrolled, and the rates have to be set by statute between 125 and 150 percent of the average rate for a small group case. And so we are limited by statute and through regulation by the insurance department as to how high those rates can go. What has happened over the course of a number of years is that the amount of subsidy insurers have had to contribute to that pool has continually risen. The basic underlying rate has gone up essentially at the rate of inflation of medical care. However, the amount of subsidy the insurers have had to contribute has gone up at a substantially higher rate.

Mr. PICKLE. If the State has a law or provision that there is a limitation of a certain percentage they will be charged, if they find funds are going out faster than they had planned or thought, then there ought to be requirements for the State agency to meet and say if we are going to charge that—you would be faced with the problem at some point where you have to raise the premium or do something else if the cost is getting imbalanced.

Mr. SCHIFFER. We feel the beauty of this approach, as you have written it in the bill, is that the increased costs are spread broadly upon——

Mr. PICKLE. You say we have written in the bill—did you write this bill?

Mr. SCHIFFER. No, that you have written.

Mr. PICKLE. I thought you said you had written it.

Mr. SCHIFFER. I don't think I wrote it.

Mr. PICKLE. That's all right. I think I know who wrote this bill.

One last question. One of you made a mention you can't solve this problem until you handle the problem of the ERISA question here in Washington. I presume you have reference to the regulations, as I understand them, that say if a large company is a self-insurer and they write their own policy, then they are exempt from State regulation. You say that's a weakness or an obstacle to the successful operation of this. So you are saying this legislation will work only if you exempt or do away with the ERISA exemption?

Mr. BURRY. That is correct.

Mr. PICKLE. Are you all saying that?

Mr. SCHIFFER. We are all saying that, one way or another. What you have done is to provide a different incentive for employers to participate. The bill doesn't deal directly with ERISA.

Mr. PICKLE. Does this legislation that we have written, does it remove the exemption?

Mr. SCHIFFER. It does not remove the exemption but it provides the right kind of incentive for self-insured employers to participate, so the end result——

Chairman STARK. It solves the problem.

Mr. PICKLE. Thank you, Mr. Chairman.

Chairman STARK. Thank you.

I may be looking for a problem that doesn't exist, but I would ask—do you notice any kind of changes in employer-provided plans because of your existence. For example, are plans in Cleveland more apt to have longer waiting periods or be tougher on preexisting conditions on the theory that that is an easy one to negotiate because you are there in the wings for those employees not fitting a company-provided plan?

I gather you couldn't age relate company premiums because you would run into an age discrimination suit.

Mr. **Burry**. Premiums can be age related.

Chairman **Stark**. Witnesses have said if you provide that, we are going to give the companies incentive to dump problems on us.

Ms. **Zellner**. One of the original reasons for having an assessment of insurers of self-employers to begin with is these were the people making the determinations on the medical status, making decisions as to whether or not someone could be accepted in a group. Because they were in a position to make those decisions, we felt it would be proper for them to share in the costs of their decisions. I think that was the rationale for using the assessment mechanism.

Since all the people are going to pay part of the price tag, there is some restraint there to just saying we are not going to insure you, go over to the pool, because part of the bill is going to be coming back to you.

Chairman **Stark**. Do you see companies saying we are just not going to provide health insurance to employees over 58. If it is a relatively new company and if you do, there is always Blue Cross that will take you under their assigned risk and so you can, by excluding 5 to 10 percent of your employees, you can knock costs 20 to 30 percent and the State or Blue Cross is around to pick it up.

Do you see much of that, because that was what a previous witness had suggested would happen. If we do this, you would find companies opting out because they can dump their problems on the State, as it were.

Mr. **Burry**. I believe that there is that sort of dumping going on. You are in, except you, because little Johnnie has problems, that kind of thing. I sincerely believe that that goes on.

I don't believe an employer should be allowed to pick and choose. You can't have a group of 20 which is your minimum level or 22 where they say these 20 or 22 whatever it is, are in our Blue Cross or commercial insurance, but we are sending the other 2 to a pool. That kind of system won't work.

There was a study issued by the CBO in December 1982 or 1983, a study of 53 million nonpoor, nonelderly American families, and all their health care costs. Relevant to this discussion here, that study indicates in its analysis that 1 percent of those families account for 22 percent of the cost of all the families and 5 percent of the families account for 49 percent of the costs.

These are the folks that we are really talking about and dealing with here. If the situation is allowed to deteriorate through dumping or whatever, there is also the problem of means, and I think Congressman Pickle was getting at that.

If the premiums get too high, it becomes unaffordable. If this is allowed to happen, then the cost of the group, the risk pool is so astronomical that it won't work.

To repeat what was said before, the only way to do it is to aggregate the costs, have an affordable premium for the people and spread the excess risk among all employers through all insurers including the self-insured programs, because those self-insured programs tend to be the bigger employers, the cleaner industries and so on—the people that you need in the pool or supporting the pool in order to make it work.

Chairman **Stark**. I want to thank you. I thank the panel for your support and constructive criticism, and we will look forward to your assistance in trying to iron out the details of this bill so we can have a workable piece of legislation.

I appreciate your appearance.

Our next panel will discuss uncompensated hospital care.

Bruce Vladeck, the president of the United Hospital Fund of New York; Christine Grant, director of hospital reimbursement, New Jersey Department of Health; Sarah Shuptrine, executive assistant to the Governor of the State of South Carolina; Sister Caritas Geary, president, Mercy Hospital, Springfield, MA.

I ask you to proceed in the order that you are on the witness list, and expand or summarize your testimony in any way you care to.

STATEMENT OF BRUCE C. VLADECK, PRESIDENT, UNITED HOSPITAL FUND OF NEW YORK

[The prepared statement begins on p. 111.]

Mr. **Vladeck**. I am Bruce Vladeck, president of the United Hospital Fund of New York. I appreciate the opportunity to appear here this afternoon and express my admiration and general support for H.R. 4742.

I have been asked to comment specifically on some of the aspects of section 3 of the legislation dealing with uncompensated hospital care and State mechanisms to subsidize it.

Chairman **Stark**. You can all comment on as many sections as you want. We would like your expertise in this particular area.

Mr. **Vladeck**. I have some other comments on the bill in my prepared statement.

I would like to focus now on section 3. To start, based on the experience that we have had in New York and New Jersey and several other States, there is an enormous amount to be said for mechanisms to cushion the impact on institutions serving a lot of the poor and uninsured which allow those institutions to remain financially solvent, and thus remain in the business of providing care to the poor and uninsured.

I would like, in the interest of time, just to make, in summary fashion, a number of recommendations relative to this issue, and one other comment, and if there are questions, I would be happy to respond to them.

The first observation I would make is that if you are going to mandate that the States adopt, through one form or another, a mechanism for covering the costs of uncompensated care, we should take some of the lessons we have learned about hospital reimbursement and hospital costs over the last decade and make sure we are talking about the reasonable costs of necessary medical care. That shouldn't be overlooked in terms of where some uncompensated care may come from.

Second, I caution you not to seek to mandate any overly elaborate system of distinguishing between what is customarily called charity care and what is customarily called bad debts. You can distinguish between them on a case-by-case basis, but I think the last thing we want to do is reinvent the kind of means-testing bureaucracy we have in our public assistance program in 6,000 hospital billing offices in the United States.

If you take seriously the question of people unable to afford under certain circumstances, to pay for medical care, you can't make rigid distinctions between bad debt and charity care. Instead, I suggest you adopt a model used with some degree of success in New York, New Jersey, and Maryland to require certain standards of billing practices on the part of hospitals, to require admitting and billing offices to make certain kinds of determinations. Those are auditable practices, and you need to audit them.

Third, you probably don't want to encourage all uncompensated services to the same extent, and you don't want to pay $100 to one hospital for a clinic visit and $50 to another providing the identical clinic visit.

Again, we have moved away from a cost pass-through mentality and I don't see why we shouldn't adopt the philosophy of paying in a discriminatory way, more for things we want to encourage as a matter of policy—for example, out-patient services—and less for things we don't want to encourage, perhaps the last days of in-patient stays or certain DRG's.

Fourth, the data suggest that about 10 percent of the hospitals in the United States provide about 40 percent of the unreimbursed care, which is to say that the average hospital in the United States provides a relatively small part of its total revenue. Many provide substantially more and a relatively small number are severely impacted.

If we believe all the rhetoric about hospital competition and about letting the marketplace play out, except to the extent we are going to fix it through mechanisms such as this, then some amount of bad debt is a cost of doing business and hospitals have lots of sources of revenue in a competitive environment. There is no reason to mandate that you pay 100 percent to everybody.

One of the things we are talking about in New York is to say that, as a condition of doing business, every hospital has to provide the first 2 or 3 percent of uncompensated care from its own resources and target whatever funds you might make available to those institutions with the greatest need in terms of the largest volume of free care that they provide.

The next recommendation I would make involves the issue, and Christine Grant may want to say something about that, that gave us the most trouble in New Jersey.

We have a lot of subsidies in the system already, particularly in terms of local and county tax levy supporting unreimbursed care, and if you are not careful, you may unintentionally create enormous incentives for county commissioners and local aldermen to get out of subsidies that they have historically provided. It may be good public policy to do so, but you need to address up front the issue of whether or not you want the maintenance of the historic level of subsidies from other jurisdictions and other units of government, or whether you want to pass it on to more general financing mechanisms.

Similarly, I think you have to require maintenance of effort on the part of hospitals as a condition for participation in the system.

If you are going to begin to compensate some of the costs of providing unreimbursed care, then it seems to me the minimum degree of reciprocity you can expect is for hospitals to at least maintain their historic level of effort.

Seventh, we have experimented in the so-called waiver States and other States with both a direct-price add-on to cover uncompensated care and with the creation of formal pools in New York in which you tax hospital revenue, put it in a central pot and push it back out. I commend the latter mechanism to you, particularly in an environment that is becoming more price competitive.

If you have a hospital that is giving lots of bad debt and charity care, and you want to add on to their rates to cover for that and they are competing over price for other buyers of service, they are going to be put at a serious disadvantage.

If you create a pool to subsidize services separately from service reimbursement, you don't create that problem. You also give policy makers more flexibility.

One of the things bothering me particularly in all the States that have established uncompensated care subsidies is we are subsidizing $75 and $80 unreimbursed clinic visits when we are not paying $35 and $40 for the same visit in a private physician's office or a free-standing center. It seems to me if you have a general pooling device in which you raise money from a certain place and allocate it in a certain way, you might target some of the money better in that regard.

I think you can make a strong case that the best source of revenue for this kind of system is a tax on revenues to hospitals or perhaps a tax on revenues to all providers.

You can make a strong ethical case for that position, but as someone involved at the State level, I would emphasize that in the current political and social climate, the only way to get Uncle Sam to pay his fair share of the burden is if you tax hospital revenues. Then 45 percent of the dollars are Federal dollars, more or less, and I think that is the only equitable approach.

Other mechanisms can also be just as effective at raising the money, but I think they are inferior from an equity point of view.

My last point, and I would be happy to pursue this, is that in fact for some of the low-income population of the United States, we have a system of coverage for health care needs that is substantially better than bad debt and charity subsidies to health care providers, and I suspect better still than subsidized pools of privately based insurance, and that is Medicaid, which is in many ways an excellent insurance program.

I am aware of current fiscal realities, but I hope as we address the gaps in coverage in the current population, we don't forget that to a considerable extent those gaps are there because the proportion of the job that Medicaid is supposed to do has shrunk continually over the last decade.

In the long term, the best way to get good coverage and good health services for the low-income people of the United States is probably through the Medicaid Program.

I very much appreciate the opportunity to be here and I would be happy to take any questions or provide supplemental information.

Chairman STARK. Thank you.

STATEMENT OF CHRISTINE M. GRANT, J.D., M.B.A., DIRECTOR, HOSPITAL REIMBURSEMENT, NEW JERSEY DEPARTMENT OF HEALTH

[The prepared statement begins on p. 118.]

Ms. GRANT. I am Christine M. Grant, director of hospital reimbursement in the New Jersey Department of Health. Thank you for the opportunity to testify concerning New Jersey's current statewide plan for payment of uncompensated care and H.R. 4742, particularly section 23.

New Jersey and its Governor are national leaders in both hospital cost containment and State financing mechanisms for uncompensated care.

Even HCFA's proposed Medicare rules published last week acknowledge that New Jersey's prospective rate-setting system has kept its hospitals operating margins among the leanest in the country and at the same time our system pays our hospitals in full for uncompensated care they provide.

This has been at a cost of over $1 billion since 190, now $300 million each year. We have had no horror stories in New Jersey concerning patient dumping or denied access to care.

Under the New Jersey system, the private payers and Federal payers, Medicare and Medicaid, have shared equitably in the burden of paying for the care of uninsured persons in return for the benefits of the cost containment efforts they enjoy.

Simply stated, our State law entitles hospitals to add approved constrained cost for uncompensated care as addons to every paying patient's DRG rate.

Medicare and Medicaid pay according to New Jersey rules by virtue of the Medicaid waiver and the Medicaid state plan.

Because we recognize the growing problem of maintaining access to health care for the uninsured, we welcome this committee's attention to the important problem, but we must warn that the states, the private purchasers of care and the hospitals are not able or willing to carry the burden of the uninsured without maintenance of Federal effort.

For example, the proposed Medicare disproportionate share rates are willful examples of maintained Federal effort. In fact, New Jersey will soon be forced to terminate its Medicaid waiver and in turn have to go to an alternative mechanism of financing alternative care, uninsured care, if the HCFA-imposed half percent inflation is passed.

Chairman STARK. If I decide to have my appendix out in New Jersey and go to an HMO or to a private hospital, is there something added to my bill—if I just pay for it, I don't have insurance? Is there a tax, like a room tax?

Ms. GRANT. It is not portrayed as a tax. We use a technical term "markup." That includes a tiny percentage which in turn relates to uncompensated care, capital graduate medical education.

Chairman STARK. Is it a fixed percentage?

Ms. GRANT. Our statewide add-on for uncompensated care is about 7 percent. However, in our system a hospital varies the addon, depending on its own amount of disproportionate patients, uninsured patients.

Chairman **Stark**. Basically, if I am a vice president in charge of benefits for a company, I just figure that it is costing me 7 percent additional in benefit outlays to take care of this in New Jersey and if I am a private individual and decide to have an elective surgical procedure, I will pay 7 percent more than if I went across the river to New York?

Is it in the bill where I can see it——

Ms. **Grant**. I think the fair answer to that is if you were an average individual, you would see something labeled mark-up and would not be explicitly aware of what it was for.

In essence, our view is that under the—this is a comment on the alternatives of maintenance of Federal support—that in essence Medicare disproportionate share regulations would pay about $15 million per year as compared to the $90 million they currently pay under the waiver.

Essentially we are permitted to allocate excess Medicare payments as we see fit. Under the disproportionate share of regulations, our hospitals would yield a lot less.

So given this disproportionate reduction of Federal effort and the imminent plan to further medicare and Medicaid cutbacks, the State of New Jersey would be particularly concerned if a new Federal law were to mandate State financing mechanisms for the uninsured either at the expense of its State's revenue or those of its private sector.

My written testimony and supporting materials goes into a lot of technical background about our system.

Let me list a few of the specific language concerns which we respectfully suggest you might consider in section 3. Several are similar to what Dr. Vladek suggested.

We assume that it should be made very clear that this bill does not require payment from State revenues for care for the uninsured nor do we feel that it is particularly appropriate to tie participation to medicare—to tie the State plan to Medicare participation.

Third, the definition of uninsured and underinsured could be handled with somewhat more specificity. I do agree that when you get beyond uninsured and underinsured that the distinctions between bad debt and charity become rather vague and more trouble than they are worth.

We suggest that the reasonable payment mechanisms described in the bill be extended to make explicit that prospective rate-setting systems based on either case mix or capitation approaches would be considered reasonable by the Secretary of HHS as reasonable State plan approaches.

Another comment is that the bill as drafted certainly does limit the plan to hospital care, and you have heard from several witnesses that this is an inherent constraint of this type of bill, essentially paying for the uninsured in the most costly of settings. We haven't solved that problem ourselves, but it is one that we think is an important one to keep on the table.

There are two proscriptions in there which are particularly troublesome to us.

The first is to disallow the payment mechanism to extend to payment for Hill-Burton care or what I would term uninsured Medicaid patients. Our reading of the Hill-Burton law suggests that although hospitals must provide free care, it does not necessarily preclude those hospitals from ultimately obtaining payment for the care from sources other than the patients served and we feel those two proscriptions would provide negative incentives to the hospital.

There are a couple of issues which I think could engender a better Federal-State partnership in this undertaking.

First, Congress should make the law explicit that neither the medicare law nor disproportionate share Medicare regulations are intended to preempt the development of state financing mechanism for the uninsured as long as the Medicare Program does not pay in the aggregate more than it would otherwise.

If the state wishes to allocate those medicare payments in excess of what its own reasonable State payment limits are for the use of the uninsured, it should be permitted to do so.

Second, the current exemption of self-insured entities from State mechanisms would severely constrain the ability of the State to establish equitable pooling or other financial arrangements.

Third, we would encourage some support for greater flexibility and enthusiasm than currently exists with respect to the Secretary of HHS and innovative State Medicaid plans, expansion of medically needy programs or Medicare waivers.

In summary, we would also suggest that should there be a mandate which would link Medicare participation to this that we would welcome much more specificity as to the secretarial responsibility. To leave entirely to secretarial discretion such an important issue as Medicare participation statewide could disadvantage a State.

We appreciate your interest in entering this field, care for uninsured which New Jersey has been in for 6 years and I would be happy to answer any questions you may have.

Thank you, Mr. Chairman.

Chairman **Stark**. Thank you very much.

Ms. Shuptrine.

STATEMENT OF SARAH C. SHUPTRINE, EXECUTIVE ASSISTANT FOR HEALTH AND HUMAN SERVICES, OFFICE OF THE GOVERNOR, STATE OF SOUTH CAROLINA

[The prepared statement begins on p. 122.]

Ms. **Shuptrine**. I would like to express appreciation for the invitation to present to you information on the South Carolina Medically Indigent Assistance Act which was signed into law effective July 1, 1985.

Gov. Richard W. Riley and Representative Robert L. Helmly, chairman of the Joint Legislative Health Care Planning and Oversight Committee, have worked diligently to maintain a partnership of effort between the public and private sectors in the development, passage and implementation of the act.

The act was the culmination of several years of study. It has three major goals: One, to improve access to health care for poor citizens, primarily children; two, to reduce the cost shifting which was occurring due to the lack of a plan to compensate for the acute care needs of the indigent; and three, to institute cost-effective measures into the administration of the Medicaid Program. There are a number of specific requirements which assure that the overall cost of health care is monitored and which establish an information base to provide policymakers and administrators adequate information needed for future decisions to assure that the act is meeting its purpose.

Specifically, we raised our AFDC/Medicaid eligibility level from 27 percent of the Federal poverty guidelines to 50 percent and include intact families. We also created a statewide fund for in-patient hospital care for persons who cannot qualify for Medicaid and whose incomes are below 200 percent of poverty. All hospital costs for persons with incomes between 50 percent and 100 percent are fully covered by the fund. Persons with incomes between 100 percent and 200 percent of poverty are required to assist in payment based on a sliding scale. The appendix to my remarks contains detailed information on eligibility, covered services and the funding mechanism.

The educational factor was integral to this effort and was of significant value in achieving support for passage. Most people in our State and in our Nation think that persons who have incomes below the poverty line are covered by programs like AFDC and Medicaid. You know that this is not the case. There is no national minimum level of eligibility for poor families with children. As a result, the eligibility criteria for these vital national poverty programs varies from State to State producing a patchwork quilt effect rather than equal access to national services. There are approximately 35 States in this country which have AFDC/Medicaid eligibility levels below 50 percent of the poverty level.

Women, infants, and children suffer the most from this lack of uniformity. We found in South Carolina that 43 percent of the indigent care admissions to hospitals were related to obstetrics, gynecology, and pediatrics. This finding is significantly related to the indigent care cost issue, but far transcends it. By increasing the AFDC/Medicaid eligibility level, we have provided access to primary and preventive care resources, not just acute care, for thousands of poor families. The cost of not providing for preventive services is substantial. Therefore, we view our action as being fiscally responsible and fiscally conservative. Prevention is, of course, the goal of the current effort in Congress to address the health needs of pregnant women and infants whose incomes are above a State's AFDC level, but below 100 percent of poverty. Governor Riley has asked me to express the appreciation of the National Governors' Association and the Southern Governors' Association for your support of this initiative.

Who pays for indigent care? This is always the key question. In looking at the issue of equitable financing, it is important to recognize that when Government fails in its responsibility to fund health services for the poor, payment for indigent care shifts to third-party payors. And, in too many cases, care is not sought by the poor until the need is for acute care, thereby increasing the costs because preventive care was not accessible.

The financing of the South Carolina Medically Indigent Assistance Act achieves a fair and equitable cost sharing for indigent care. The State continues to provide all of the AFDC match and most of the Medicaid match and the Federal Government contributes its matching share for both the AFDC and Medicaid components. Counties contribute toward the Medicaid match and also fund half of the Medically Indigent Assistance Fund, which is the pool of funds that provides assistance for persons below 200 percent of poverty who are uninsured or underinsured. The other half of this fund is provided by all general hospitals licensed by our State. With the cooperation of the South Carolina Hospital Association and the South Carolina Association of Counties, formulas were developed and incorporated into the act which determine the amounts paid by each county and by each hospital. These contributions are provided quarterly. The actual eligibility determinations for the fund are handled at the local level, but the eligibility guidelines are statewide.

In the first 6 months of our program, we have enrolled a net increase of 11,203 individuals in the AFDC/Medicaid Program. We are working toward an estimated enrollment of 42,600, of which 25,000 are expected to be children. We did include intact families in that base population. We think that is extremely important. The fund began on January 1, 1986, and was funded at $7.5 million for one-half of this fiscal year. In the first 4 months, it has expended $4.7 million and we expect it to be exhausted by the end of the fiscal year on June 30. Next year it is funded at $15 million.

Some findings to date are:

One, the Medicaid medically needy program has decreased by 22 percent since the AFDC/Medicaid expansion. This was, of course, part of the plan; and

Two, 75.7 percent of the persons served by the Medically Indigent Assistant Fund have incomes below 100 percent of poverty, 16.2 percent are children under age 18 and 59.4 percent were women, 20 percent of all claims were for pregnancies or newborn care.

We see future issues to be as follows:

One, evaluation of the equity of the financing mechanism;

Two, evaluation of the eligibility process to assure statewide uniformity of application;

Three, development and evaluation of the cost containment mandates included in the act;

Four, development of a plan to provide primary and preventive care, not just acute care, for South Carolina families between 50 percent and 100 percent of poverty; and

Five, assessment of eligibility criteria and covered services as they relate to appropriated funds.

Thank you once again, Mr. Chairman, for your interest in this initiative. I would be glad to answer any questions you might have.

Chairman STARK. Thank you very much.

Are you suggesting that I could get support out of the Southern States for Federal standards for AFDC eligibility?

Ms. SHUPTRINE. I am saying, Mr. Chairman, that the Southern States created a task force during the past year on infant mortality and out of the 11 States in this country that have the highest infant mortality level, 10 are in the South and much of that has to do with access to care.

Chairman **Stark**. I understand that, but do you think I could get my colleagues from those same States to support legislation-mandated Federal standards——

Ms. **Shuptrine**. A minimum eligibility level, you could get it from South Carolina. I mentioned the educational component, which I feel contributed to the realization on the part of policymakers and the public that people have to be so poor to be eligible——

Chairman **Stark**. This is not germane to this committee, but for the Public Assistance Committee on which I serve, this would solve a lot of problems in dealing with adequacy of care.

I would like to hear more about that because that comes as a surprise to me, that southern Governors would support that because perhaps the southern congressional delegations have always felt that that was an intrusion on States' rights or whatever their objections are. It hasn't been a very popular thing.

We will talk about that more some other time. Thank you, Ms. Shuptrine.

Sister Geary.

STATEMENT OF SISTER CARITAS GEARY, S.P., CHAIRPERSON, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, TASK FORCE ON HEALTH CARE OF THE POOR, AND PRESIDENT, MERCY HOSPITAL, SPRINGFIELD, MA, ACCOMPANIED BY BILL COX, VICE PRESIDENT, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Sister **Geary**. I am Sister Caritas Geary and I am president of Mercy Hospital, but I am here today representing the Catholic Health Association of the United States.

Here with me is Bill Cox, CHA vice president whose office is in Washington.

I am grateful to have this opportunity to express the Catholic Health Association's strong support for the Improved Access to Health Care Initiative, H.R. 4742.

During the past year, I had the distinct honor of chairing a select CHA task force on the needs of our Nation's health care poor. Following a thorough examination of the problem, our task force confirmed what many others have long suspected, the number of poor people without adequate health insurance in the United States is large and has recently grown larger.

Several factors explain why this has become an increasingly urgent concern. A market environment driven by price competition among health care providers requires that persons be able to pay for the health care they need. In such an environment, there are few, if any, economic incentives to provide care for those unable to pay. Because many poor persons lack either public or private health insurance, and many more are underinsured, their access to health care services is seriously diminished. The problem is further aggravated by employers' and insurers' understandable attempts to bring their own health care insurance costs under control by reducing payments to providers, thus limiting dollars previously available for the care of the poor. Lastly, unprecedented Federal deficits and disproportionate budget cuts in health care reimbursement have exacerbated the overall problem by seriously impacting such programs as Medicare and Medicaid.

The task force's findings and recommendations are contained in the report, "No Room in the Marketplace: The Health Care of the Poor." The report was adopted on April 24, 1986, by the CHA Board of Trustees. We have provided each member of the subcommittee with a copy of the report.

I want to emphasize that the report challenges all sectors of society—especially Catholic health care providers, government and employers—to make additional immediate commitments on behalf of the poor.

With respect to the role of Government, four of the five key elements of the improved access to health care initiative are similar to CHA task force recommendations. The two compare as follows:

Both seek an extension of employment-based health insurance coverage for laid-off workers and their dependents.

Both seek the establishment of subsidized State health insurance coverage for laid-off workers and their dependents.

Both seek the establishment of subsidized State health insurance pools to allow people without access to employment-based coverage to buy individual health insurance regardless of their health status.

Both would require States to establish a mechanism to fund hospital charity and unreimbursed care.

Both would change the tax laws to encourage more employers to provide health insurance to their employees and employees' dependents.

CHA believes that if enacted, the provisions of H.R. 4742 will go a long way toward ameliorating the problem of no health insurance or inadequate health insurance among the Nation's health care poor.

We commend you, Mr. Chairman, and the bill's other cosponsors for introducing the legislation and pledge our support for the bill's enactment.

Since the red light hasn't gone on, let me make a few other comments.

CHA has determined from our own membership that we don't have an adequate understanding of uncompensated care. We intend to start an effort on July 1 among our members to try to get a better handle on that number and we would be very happy to share that information with you when we have it.

Chairman **Stark**. Thank you.

Sister **Geary**. Second, Dr. Leon—I won't try to pronounce his name, from the University of Michigan—indicated that 4 months was too short a time. We recommend 6 months for laid-off workers.

I would like to address something that is on page 42 of our report. Among our recommendations, the task force believes the problem of no insurance or inadequate insurance among newly unemployed and the working poor persons can be ameliorated by adopting one or more of the following programs at the State level. Mandate the provision of health insurance.

One broad option would require States to mandate that employers provide health insurance coverage just as employers are required to pay unemployment compensation and Social Security.

A special tax credit could be made available to those employers who provide dependent coverage. This provision requires that Congress amend the Employment Retirement Income Security Act to allow States to legislate such mandates.

[Prepared statements of the panel follow:]

Statement

on

The Health Care Improved Access Act of 1986
(H.R. 4742)

by

Bruce C. Vladeck
President
United Hospital Fund of New York

Mr. Chairman, members of the Committee, my name is Bruce C. Vladeck. I am President of the United Hospital Fund of New York. I am delighted and honored by the opportunity to appear before you today to offer my comments and observations on H.R. 4742, "The Health Care Improved Access Act of 1986."

I believe that H.R. 4742 represents a significant and extremely timely step towards addressing the problems of America's uninsured and underinsured, and the needs of the institutions that serve them. I would like to begin by expressing my enthusiastic support for the thrust and intent of the bill, as well as for most of its specifics. I have a few concerns, which I will raise later.

Staff has asked me to focus my comments on Section 3 of the proposed legislation, which addresses payments to hospitals to compensate them for unreimbursed services. I am pleased to do so. In order to put my remarks in the appropriate context, however, I thought it might not be inappropriate to say a word or two about my own experience with this issue.

I was personally responsible, as Assistant Commissioner of Health from 1979 through 1982, for the design and implementation of the mechanism for reimbursing hospitals for uncompensated care employed in the State of New Jersey as part of its all-payer hospital rate-setting system operating under a Medicare waiver. I have also been involved, since 1978, as a member of the Council on Health Care Financing in New York State, and thus in the discussion and policy development of mechanisms for reimbursing bad debt and charity care in New York. Perhaps most immediately, the United Hospital Fund has been engaged for over 100 years in the distribution of charitable funds to voluntary, not-for-profit hospitals in the City of New York, using need and community service as criteria for allocating distributions. We are thus continually engaged in the process of evaluating definitions of need, of seeking to refine data collection and measurement, and of performing analyses of the impact of different distribution formulas.

From this background, the most important thing I have to say is to congratulate the sponsors of H.R. 4742 for their thoughtful and direct approach to this issue. We have demonstrated, in New York and New Jersey, that well-designed systems for subsidizing uncompensated care can maintain the viability of institutions on which the poor and uninsured are especially dependent and maintain access to care, within a framework of real cost containment. Failure to adopt such a system, in an era of financial stringency, must lead to reduced access, bankrupt hospitals, or both.

I propose to organize the balance of my remarks as follows: First, I will express my one significant reservation about Section 3 of the proposed legislation. Then, I will offer some general observations about uncompensated care. After that, I will make some recommendations as to how the provisions of Section 3 might be implemented by states, with concomitant observations about appropriate modifications in the language of Section 3. I will conclude with some general observations.

My one significant reservation about Section 3 is the tying of state plans for payment for uncompensated and charity care to Medicare conditions of participation for hospitals. I believe I full understand the reasons why, in terms of legislative authority and committee jurisdiction, the authors of H.R. 4742 have taken this approach in order to establish an efficacious mechanism for inducing state compliance, but I fear that this method may run the risk, under particular political or state legislative circumstances, of putting Medicare beneficiaries at risk for failures on the part of their state legislatures, or on the part of the Executive Branch of the federal government in administering this provision. That would obviously not be consistent with the sponsors' intent. If I may, I would like to suggest an alternative: Under a number of titles in the Social Security Act, the federal government provides pro rata reimbursement to states for administrative activities. Sanctions associated with reduction or elimination of Federal Financial Participation for those administrative activities might have a more direct and salutary effect on state governments than sanctions directed at the entire hospital community within their states. Alternatively, one might wish to look at payments under Titles 18, 19, and 5 to institutions operated directly or indirectly by agencies of state government.

Uncompensated Care: Some General Observations

In evaluating the problem of uncompensated services provided by hospitals, and seeking to design appropriate policy responses, one of the first things to be recognized is the unevenness of the problem's impact. The poor and uninsured are not randomly distributed across the landscape of the United States; to the contrary, they are not only concentrated in inner cities and some rural areas, but perhaps increasingly so. Further, in many communities the responsibility for care of the poor has traditionally fallen disproportionately on one or several hospitals, typically public institutions. Thus, it has been estimated that perhaps 10% of the nation's hospitals provide between 40% and 50% of the unreimbursed hospital services. If one views the problem of unreimbursed services as primarily one (although I'm not sure it should be so viewed) of insuring access to health care for the poor and uninsured by providing for the survival of institutions upon which they are disproportionately reliant, then in fact it may be possible to develop strategies focussing on a relatively small percentage of all hospitals.

At the same time, unreimbursed services are not a problem uniformly distributed across all sorts of hospital care. In large urban areas, such as those of the northeast, more than half of uncompensated care provided by hospitals typically involves outpatient departments and emergency rooms, which serve in effect as the providers of primary care physician services to their communities. In other settings, a large proportion of uncompensated care may be attributable to maternity and neo-natal services, reflecting inadequacy of insurance coverage for pregnant women, particularly first-time pregnant women. In those instances, targeted pre-natal and maternal care programs may be a more appropriate policy response.

My reading of H.R. 4742 suggests that its sponsors sought not only to address the problems of particularly impacted hospitals, whose needs were to a limited extent addressed in the disproportionate share provisions for Medicare payment in the 1985 Reconciliation Act, but also the more general issue of insuring broadly-based access of the uninsured to hospitals of all kinds in an increasingly competitive environment. I certainly can't quarrel with that approach, particularly since it is consistent with those we employed in New Jersey and New York. But I think the issue should be brought to the Committee's attention.

Another general issue about uncompensated care that needs to be brought to your attention is the relationship between the phenomenon and insurance patterns in particular communities. Obviously, the problem of uncompensated care arises in the first instance because people do not have health insurance, or don't have enough health insurance, or don't have very good health insurance. But, in fact, the relationships are more complex than that. The issues of the uninsured and of uncompensated care have reached such prominence in the last several years, for example, to a considerable extent because of restrictions on the Medicaid program, which have resulted in the availability of Medicaid coverage for a diminishing share of the poor and near-poor population. In general, the more generous a state's Medicaid program, all other things being equal, the less uncompensated care its hospitals will need to provide. Similarly, in states such as New York with relatively generous "spend down" eligibility procedures under Medicaid, outpatient services comprise such a large proportion of uncompensated care because most uninsured low income persons encountering the expenses of a lengthy hospitalization have a reasonably high probability of eventually attaining Medicaid eligibility retroactive to the date of admission.

I also very strongly suspect that the reported growth in unreimbursed services in recent years is closely related to the increasing popularity of expanded deductibles and co-insurance in private insurance policies. I am familiar with all of the theoretical arguments for increasing out-of-pocket liabilities for consumers at the point of service, although I remain highly skeptical about their effect, but there is no question that traditional private insurance service benefits, of the type now so freely scorned by economists and other analysts, eliminated the problem of patient bad debts for populations with such coverage.

This issue is closely related to the problem of drawing the boundary between what we have traditionally called charity care, and what is appropriately treated as bad debts or patient uncollectibles. While the distinction can be very clearly made in theoretical and accounting terms, in practice the line often becomes impossibly blurred. Take a hypothetical example: If the dependent child of an uninsured employed worker who earns the federal minimum wage incurs inpatient expenses of several thousand dollars, we would probably readily accept provision of that care as a charity service. But if the same employee has employment-related hospital insurance with a $500 deductible, do we expect him to reasonably be able to pay the entire deductible? Should the $500 be defined as charity care in states where the family income would qualify them for Medicaid? Or as charity care only if the dependent child lives in a single-parent household, thus qualifying them as categorically related if their income is low enough? Or if the child resides in a state with relatively generous cash assistance and Medicaid eligibility standards, as opposed to a low-benefit state? Or should the hospital be expected to collect $100 or $200 of the $500 deductible, writing the balance off as charity? And if they don't collect the $100 or $200, should that uncollected amount be considered a "bad debt."

In other words, the ability to pay for medical services is a complicated and often situational phenomenon, connected not only to the absolute level of a patient's or a family's income, but also to the nature of their insurance coverage, the level of medical expense, the assets and employment situation of the family, and so forth. While there is no question that hospitals should be required to make every reasonable effort to collect all payments for which they can reasonably ask, we have enough trouble with the administration of eligibility for our cash assistance and related programs to expect hospitals to mimic the entire eligibility definition and means-testing apparatus for every less than fully-insured patient, especially in those instances where the potential charity and/or bad debt involves an emergency room or clinic visit with a total cost to the institution of $40 or $50 or $60. In summary, I believe that any system for accounting for, and certainly for reimbursing, the expenses associated with uncompensated care must mandate and enforce requirements for good billing practices on hospitals. At the same time, however, attempting to be overly rigorous in distinguishing between "charity care" and "bad debts" strikes me as an excessive preoccupation with an essentially semantic distinction.

A related problem in grappling with the issue of uncompensated care is the need to distinguish between costs and prices. One of the recurring policy dilemmas we have encountered in the northeast is that so large a proportion of uncompensated care involves outpatient services in hospitals for which the unit cost is significantly greater than equivalent services in private physicians' offices, if only there were private physicians' offices in the same communities. To recognize the "fully allocated cost" of bad debt and charity care in hospital outpatient departments may therefore be to recognize the costs of a variety of hospital overhead departments allocated to those services in accordance with Medicare cost reporting rules. From a more global perspective, it might be a more efficient and effective use of community dollars to make them available as a direct subsidy to high-quality freestanding providers. Funds are, of course, hardly ever so fungible, but I think we need to worry about this general issue.

Conversely, to the extent that a large share of bad debt and charity services are attributable to maternity and neonatal care, hospitals have probably traditionally significantly underpriced these services. Appropriate compensation for them thus demands, at a minimum, very sophisticated evaluation of the real costs of service provision.

Some Recommendations

In light of these observations, I would like to make the following recommendations for state plans as outlined in Section 3 of H.R. 4742, in the areas, respectively, of measuring and defining uncompensated care, reimbursing uncompensated care, and financing that reimbursement. Most of these recommendations are perhaps most relevant to actual implementation of H.R. 4742 or some equivalent, but it might be desirable to incorporate some of them directly into legislative language.

To begin with, for example, all of our experience with hospital reimbursement over the last decade or so suggests that provision should be made only for the unreimbursed reasonable costs of medically necessary services for which no payment is made, rather than for all costs. Tests of reasonableness may appropriately vary from state to state, and even from service to service, as will techniques for determining medical necessity. But as we have begun to move away from purely cost-based reimbursement in all other aspects of hospital payment, it would make no sense to let it creep back in in the treatment of uncompensated care. Further, while all of the standard industry definitions of uncompensated care now clearly distinguish it from "contractual allowances" and other discounts associated with limitations on the willingness of payers to purchase hospital services at list prices, care must be taken to differentiate between reasonable and appropriate costs not covered by collected revenues due to inability of patients to pay from other reasons why revenues go uncollected in an increasingly competitive and negotiated pricing environment.

It is also essential, especially given the difficulty of making fine distinctions between bad debt and charity care, that general norms for hospital billing practices be established and enforced as part of any system for reimbursing uncompensated care. Here, the experience in those states which have been in a leadership position in this area, specifically New Jersey, New York, Maryland, and Massachusetts, should provide appropriate models not only for billing practices standards, but also for surveillance and audit procedures.

A somewhat more subtle issue in the measurement of bad debt and charity care arises from the differential in costs, perhaps even in reasonable costs, for different kinds of services among different hospitals. There is some question in my own mind as to whether it is sound public policy to reimburse institution X $30 for a routine clinic visit for an indigent patient, while reimbursing facility Y $40 for an equivalent visit. For many years, in our own determination of community service need at the United Hospital Fund, we have used service volume, defined in number of inpatient days and outpatient visits, instead of direct economic costs, as a way of achieving greater equity across a range of institutions with widely varying unit costs of service production. Doing so would also permit policymakers to consciously provide specific incentives and disincentives for specific sorts of services, rather than merely providing a passthrough for financial losses. Thus, for example, one might conclude it was desirable public policy to cover 100% of the cost of unreimbursed outpatient services, or 100% of the costs of first two or three days of inpatient admissions, but something less than 100% of the costs of additional inpatient days.

In terms of reimbursement, while I think it is imperative that public policy provide for the provision of funds to hospitals that service uninsured or underinsured patients, there seems to me to be no overwhelmingly compelling reason why that reimbursement should cover 100% of even the reasonable costs of such services. To some extent, some volume of bad debts is a cost of doing business for any institution, and if we believe in a competitive environment for hospitals, there is no overwhelming reason why they should be guaranteed total protection against all non-collection. More importantly, assuming any fixed pot available for distribution of bad debt and charity care funds, it is necessary to target those funds where they are most needed. And again, the data on amounts of bad debt and charity care across hospitals suggests that the great majority of all institutions provide a relatively small amount of service for which they bill and don't collect, but that a much smaller proportion of all institutions provide the great proportion of real charity care.

Further, for all the competitive pressures, the hospital industry in the aggregate remains a relatively healthy one, which benefits considerably from a range of public and quasi-public subsidies and other forms of support. Within the context of an explicit public utility style sort of regulation such as that which prevails in New Jersey, New York, Maryland, and perhaps less than a handful of other states, it is necessary to recognize the full costs of bad debt and charity care when regulatory oversight is not only not undertaken, but in fact specifically rejected, then it seems to me that there is no compelling reason to provide bad debt and charity subsidies to every institution, or in the same proportion relative to need to any institution.

In this regard, it might be useful to consider an idea we are currently playing with in New York, which is to establish some threshold - perhaps 2% to 3% - which might be considered the minimum expected contribution to bad debt and charity care expected of every institution as a condition of licensure. Reimbursement for uncompensated care costs would only involve expenses in excess of the threshold. Hospitals would be expected to contribute the balance from surpluses gained in operations, or from non-operating revenues such as those associated with philanthropic contributions or other subsidies.

Similarly, any plan or program to address the problem of uncompensated care for hospital finances must take adequate cognizance of existing subsidies for those purposes. In general, it is probably not sound policy to provide the sources of those existing subsidies with the opportunity or excuse for discontinuing them. This issue is particularly important relative to local subsidies to public, and some private institutions, which in many instances have long existed. In New Jersey, our statute unfortunately made it impossible for us to require county and municipal governments to maintain their traditional levels of support for care of the medically indigent, thus over time in essence transferring responsibility for some part of the subsidization from local tax payers to health insurance premiums. In New York, we have dealt with this problem through the much blunter instrument of providing different proportional subsidies to public as opposed to private hospitals. Neither approach is, in my view, optimal, but clearly any state plan for a subsidization of uncompensated care must adequately take pre-existing subsidies into account, and provide mechanisms to insure that they will be maintained.

Similarly, the system of payment for uncompensated care must in some way provide institutions incentives to maintain their historical level of effort, or better yet to increase it. Given the difference between marginal and average costs for most services provided by hospitals, 100% volume variability for services above a minimum threshold probably accomplishes this intent, by insuring hospitals some degree of potential profits from increasing services while causing disproportionate revenue losses from service reductions, at least within a narrow range of volume fluctuations. However, it is probably also desirable, as had been the practice in New York, to also impose explicit performance requirements on hospitals as a condition for receipt of bad debt and charity care subsidies. Such requirements should begin, at a minimum, with a maintenance of historic effort, but might well be tied to the perceptions of appropriate policymakers about changes in the need for, or distribution of need for, unreimbursed care.

On a somewhat different tack, the increasing prevalence of price competition, or at least perceived price competition, among hospitals creates the potential anomaly of putting hospitals which provide significant volumes of uncompensated care at a competitive disadvantage if uncompensated care is funded through an add-on to hospital rates. A more desirable approach is probably to pool the available funds, and distribute them to institutions on some basis separate from itemized fee-for-service payment. Once funds for uncompensated care are pooled, of course, the possibility arises of using at least some of the funds available in the pools for purposes other than direct dollar-for-dollar payment to hospitals. Perhaps the most imaginative use of such funds is that planned in the state of Florida, where they propose to take some portion to apply as the state's share of costs for expansions in their Medicaid program. It should not be hard for creative state policymakers to imagine other applications for such funds.

In that regard, I would particularly urge for your consideration the fact that hospitals which have historically been providers of disproportionate amounts of care to people unable to pay for it often have a number of financial problems over and above their difficulty in covering current period operating costs with current period operating revenues. In particular, the customary syndrome among such institutions involves serious working cash shortages, considerable short-term debt associated with the financing of working capital needs, and the inability to plan for, let alone provide, needed replacement and modernization of plant and equipment. Both New Jersey and New York have recognized these problems in their policies for dealing with the phenomenon of uncompensated care: New Jersey by providing a "working cash infusion" for hospitals entering the system in seriously adverse working capital positions; New York by providing additional pooled subsidies for "distressed hospitals." It would seem to me desirable for Section 3 of H.R. 4742 to contain language encouraging similar initiatives on the part of state governments in the establishment of state plans.

Of course, the most sensitive issue in the establishment of such state plans will be where the funds are to come from. We hear a lot of rhetoric these days about how uncompensated care and the uninsured are everyone's problems, and need participation in their solution from all sectors of society. I personally believe that a strong case can be made to the effect that, in the last resort, access to high quality health care for all American citizens is a responsibility of the federal government, but I will defer to your superior judgment as to short-term political realities in terms of recognition of that federal responsibility at the moment.

Short of an expanded direct federal role in financing care for the uninsured and underinsured, I think it is entirely legitimate to finance services to those populations by taxing health care providers and health care payers in some combination appropriate for particular economic and political circumstances as they vary from state to state. Of course, as a practical matter, taxes on providers often become de facto taxes on payers. The critical point is, as already noted, that the hospital industry in the aggregate appears to be receiving enough revenue from all payers to finance care for all who need it; the problem is really the classical one that the rich are getting richer and the poor poorer, suggesting the appropriateness of some redistribution justified in terms of equitable treatment. At the same time, however, I suggested earlier that the problems of bad debt and charity care arise in the first instance from the particular policies and practices of payers, both public and private. To the extent that their behavior creates the problem, it seems to me only reasonable that they should have a hand in solving it. Medicare, of course, has long observed this principle to the limited extent of reimbursing hospitals for bad debts associated with Medicare beneficiaries; but that principle should be expanded on the notion that availability of services to all who need them is a responsibility that ought to be shared among all organizations in both the public and private sectors that purport to provide service to the population by offering health insurance. Again, the actual mechanics of any "taxes" to generate revenue from hospitals, payers, or both, are neither particularly mysterious nor do they need to be spelled out in great detail in federal legislation. The principles, however, should be clearly observed.

Concluding Observations

In light of the enormous potential contribution I believe that H.R. 4742 can make to the American health care system, and particularly to the availability of health care for those who are currently inadequately served by the system, I am reluctant to make any negative observations, but I feel obliged to point out that Section 3 really speaks primarily to the needs of institutions, and addresses the needs of uninsured and underinsured populations only to the extent that those populations are actually able to get good care in institutional settings. Similarly, while I applaud the thrust of the balance of the bill as an effort to expand and fill in the gaps in the system of private insurance that covers health care expenses for most Americans, it should also be recognized that in any employment-based insurance system, there will always be gaps; there will always be people who cannot get adequate coverage. The basic facts are that the real actuarial costs of decent health insurance are beyond the means of many working Americans, and that ill health, and thus the need for health services, continues to be highly interrelated both with low income and with limitations on labor market participation.

The fact of the matter is that we do have a superb system of health insurance, at least in terms of its required benefits and extent of coverage, for roughly half of all the poor in the United States. That system, of course, is Medicaid. There are many problems with the Medicaid system, but it looks a lot better than many of the alternatives. Over time (questions of committee jurisdiction aside) if we are to more thoroughly and systematically address the needs of lower-income Americans for high-quality health care services, we are going to have to address the need to strengthen and expand the Medicaid program. Doing so would obviously create further calls on public revenues, but I don't know how we can continue to consider ourselves citizens of a civilized society unless at some point we are prepared to face that reality.

Again, I am very appreciative for the opportunity to appear before you today and to express my appreciation and support for the efforts embodied in H.R. 4742. I would be delighted to answer any questions, or to provide you with any further information you might find helpful.

Thank you very much.

TESTIMONY FOR
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON HEALTH
JUNE 9, 1986
CHRISTINE M. GRANT, J.D., M.B.A.
DIRECTOR, HOSPITAL REIMBURSEMENT
NEW JERSEY STATE DEPARTMENT OF HEALTH

I am Christine M. Grant, Director of Hospital Reimbursement in the New Jersey Department of Health. Thank you for the opportunity to testify concerning New Jersey's state-wide payment mechanism for hospital care for the uninsured.

The purpose of this testimony is to review the New Jersey experience with care for the uninsured and to suggest specific technical modifications of the language of the proposed Health Care Improved Access Act of 1986.

The State of New Jersey is a national leader in development of state-wide plans for payment for uncompensated care provided in hospitals. The State's all-payer hospital rate setting law entitles hospitals to include uncompensated care costs as add-ons to every paying patient's DRG rate. All payers for hospital care including Medicare and Medicaid pay these add-ons which now annually total $300 million of a $4 billion state-wide hospital revenue base. Over one billion dollars has been paid to New Jersey's acute care hospitals for uncompensated care by all payers since 1980. The annual state-wide payments for uncompensated care are rising significantly each year. New Jersey's Governor Thomas H. Kean has been a national leader in calling for maintained access to health care for all people through strong state level efforts. He fought hard for the state's right to maintain its waiver of Medicare principles primarily in order to maintain the state-wide consensus that all payers for hospital care, including Federal Medicare, should share equitably in this social responsibility in return for the State's successful cost containment efforts that they enjoy in New Jersey. New Jersey's rate of increase in hospital payments and expenses is among the lowest in the country.

Therefore, we in New Jersey welcome the interest of this important subcommittee in addressing the dilemma of medical care for the uninsured population. While the legislation reflects a good understanding of the various aspects of this important problem, we view the proposed solution as problemmatic as it is limited to prescriptive, inflexible mandates on the states accompanied by drastic cutbacks to Medicare and Medicaid payments.

We come today to offer our experience on the subject and make clear that the State, purchasers of care, and hospitals are not able or willing to carry the burden of the uninsured alone without maintenance of Federal effort.

By way of example, Medicare payments for disproportionate share hospitals in New Jersey will be less than $15 million as compared to the total uncompensated care of approximately $300 million. While Medicare patients account for 40% of hospital care, the estimated $15 million is only 5% of the uncompensated care burden. New Jersey's concern for access to care prompted the New Jersey legislation in 1978 to amend our Health Facility Planning Act to include a provision for the payment of uncompensated care. Since 1980, New Jersey has fulfilled this mandate through its all-payer DRG reimbursement system in which Medicare participates under an 1886 waiver.

New Jersey's State Plan for Payment for Uncompensated, Charity, and Outpatient Hospital Care

New Jersey's hospital rates are prospectively established to include reasonable direct patient care costs plus add-ons for uncompensated care, administrative overhead, graduate medical education, capital, and new programs. The system provides for payment of reasonable costs associated with care for the medically indigent as an element of the total statutory revenue. The regulations define medical indigency as including:

1. The provision of health care services to individuals unable to pay for them for reasons of indigency;

2. Bad debts provided appropriate collection procedures are followed.

There is a prospective determination of each hospital's likely uncompensated care costs in advance of each rate year as part of the annual rate setting process. At year end, this projection of uncompensated care, as expressed as a percentage add-on to rates, is reconciled to the hospital's actual experience. Grants from county governments, municipal governments, or others on behalf of the medically indigent, are applied to meet the total uncompensated care. The net amount is paid by paying patients.

Since New Jersey's hospital rate setting system is an all-payer system, all payers make an equitable contribution to the cost of care. Therefore, uncompensated care is apportioned to all payers or payer classes based upon each payer's percentage of utilization. This means that if Blue Cross, as a payer, made up approximately 20% of all hospital services state-wide, an adjustment is made to assure that Blue Cross pays 20% of all uncompensated care in every hospital, regardless of the hospital-specific percentage of Blue Cross patients. This methodology spreads the burden of payment for high uncompensated care hospitals which tend to have low private insurer representation more equitably.

It is a subtle but critical distinction of New Jersey's statewide plan for payment for uncompensated care that it entitles hospitals to payment for care rendered. It does not entitle individuals. This approach eliminates the persistent problems of eligibility determination and gaps in coverage which plague entitlement programs like Medicaid. It provides coverage (insurance) and full access when the care is rendered. On the other hand, this strength is a limitation because it extends only to hospital-based inpatient and outpatient care.

Constraints of the Current System

Despite its major success in ensuring universal coverage of the uninsured when they obtain hospital care, the technique has its limitations as follows:

1. Payment for uncompensated care extends only to the most costly of inpatient and ambulatory care since the current New Jersey legislation applies only to hospitals. This approach does not of itself redirect care to the more cost-effective but equally appropriate ambulatory settings;

2. Since each hospital has its own specific uncompensated care mark-up, hospitals with the highest levels of uncompensated care (typically inner-city teaching hospitals) have the highest add-ons to rates. An unintended artifact is that these hospitals cannot price compete as effectively with the hospitals that provide little uncompensated care and which have low add-ons;

3. Uncompensated care in New Jersey hospitals has grown due to two unanticipated events. First, counties and municipalities abruptly withdrew their direct charity care payments to hospitals and, second, we believe that

> hospitals are not as aggressive as they might be with collection efforts since they know payment is assured.

Plans to Strengthen the Current System for the Uninsured

New Jersey is currently proposing several initiatives to maintain and improve its present system of payment for the uninsured. The State Department of Health is in the process of developing an uncompensated care pool which will evolve the hospital-specific add-on approach into a flat state-wide percentage add-on. The portion of this add-on above a hospital's need would be sent to a central pool, while hospitals incurring higher than state-wide average costs would receive payments from the pool. We are also investigating the demographics of the uninsured with the intent to explore ways to expand insurance coverage of both employed and unemployed persons (thereby reducing the total number of uninsured persons). There will be a greater ability to redirect high cost hospital-based care to a less costly setting under a pool approach. These modifications to the current delivery and financing of care are difficult to accomplish in today's health care cost containment climate with its heavy "competition" theme. The State's hospital association supports this approach.

Recent Medicare cutbacks have threatened New Jersey's all-payer system and its Medicare waiver. Non-federal payers are concerned that these service payment shortfalls will be passed on to them as well as increased payment for the uninsured. They view this as a double hit. This atmosphere threatens the notion that care for the indigent should be a shared responsibility of both government (Federal and State) and hospital payers.

As previously stated, we do not believe a Federal mandate to set up state plans is necessarily desirable, particularly if not accompanied by Federal support.

Proposed Health Care Improved Access Act

This bill, while correctly diagnosing the problems inherent in the uninsureds' access to medical care, however, prescribes a treatment which is contraindicated. The lack of health insurance is a more significant impediment to health care than it once was. Providers, responding to competitive market forces, have become increasingly cost conscious and, thus, less willing to provide free care to uninsured persons.

There are several sectors of the population who, for different reasons, have inadequate access to health care. Among these groups, the most direct role for government is in providing care for the poor. We oppose any further erosion in Medicaid coverage and hope to work with the Federal government to bring an increasing percentage of people below the poverty level into the Medicaid program.

There is a need for joint responsibility of Federal and State governments in addressing the problem of health care coverage for the non-poor. Governments should adopt strategies and take steps to facilitate private financing solutions that make available health insurance products to those who cannot now obtain coverage.

We oppose Federal requirements for the imposition of new state and local taxes or use of other state revenues to meet the provisions of the proposed Health Care Improved Access Act, especially when there is no proportionate participation of the Federal government. We also vigorously oppose sanctions such as a reduction in funding under Medicaid.

Federal action can facilitate state and private sector initiatives to cover uninsured individuals. The ability of states to establish pooling and other financial arrangements to meet the needs of individuals who cannot obtain health insurance is severely constrained by the exemption of self-insured entities from state mechanisms. While the uninsurable population is important, it is relatively small. The states may want to establish pools for broader groups who do not have access to affordable health benefit plans. Federal action to give states the ability to include self-insured entities in establishing such pools is critical to these initiatives.

Congress must make explicit that the disproportionate share Medicare regulations are not intended to preempt state rate setting systems from reallocating Medicare payments for coverage of the the uninsured, so long as it will not cost Medicare more than it would have paid.

Additionally, greater flexibility should be given to innovative Medicaid State Plans, Medically Needy Programs and Medicare waivers. The proposed legislation addresses an important issue. It is clear from New Jersey's specific experience that we strongly support access to medical care for the uninsured. However, the proper solution must provide States with the needed tools to develop properly the state mechanism to address these problems.

There are several technical limitations in section 3 - the State Financing Mechanism - which should be considered for modification. The amendment to Medicare would appear to extend to all hospitals including psychiatric and rehabilitation hospitals. This is very broad coverage and extraordinarily costly. To my knowledge, no state has extended payments for uninsured persons to these settings. I would note that the most liberal private plans of insurance limit this coverage. I am of the opinion that more must be known about how to resolve the heterogeneity of these services before such a big step is taken.

Section 1819(a)(1)(A) should explicitly state that payment mechanisms based on case-mix or capitation approaches are a reasonable basis. Patient by patient basis could be interpreted as a charge basis. That basis is not ordinarily subject to cost constraints. The language could include the concept of need for prospectively determined cost constraints. Reasonable and customary is also generally viewed as not subject to cost constraints. Both examples could result in requiring payment for the uninsured as amounts in excess of what is paid for insured patients. The prospective approved budget must be tied with volume and types of services or minimal care to maximize retained payments is too likely.

The proscriptions under section 1819(a)(1)(B)(1) are unnecessarily severe. The Hill-Burton law requires provision of care to charity patients. That does not mean the hospital may not charge other than the patient through an alternative mechanism to recoup cost of this care. This is negative incentive to provide charity care. The hospitals providing the most charity care are likely to be the highest Hill-Burton obligees. New Jersey successfully drew this distinction and has other payers pay for this care.

1819(a)(1)(B)(iii) should make clear that collections are for charges "approved rates" for the care. Unconstrained charges are not the appropriate payment if prospective cost controls are in place. In general, the concept of prospectively determined cost controls could be included in law. This is rapidly being accepted as status quo.

1819(a)(1)(B)(v) would unnecessarily preclude the financing mechanism from requiring payment for underinsured Medicaid recipients. New Jersey requires Medicaid via State Plan to pay the same DRG rates for their beneficiaries as do all insureds. To disallow this would provide strong negative incentive to care for Medicaid beneficiaries. This would jeopardize Medically Needy Programs, an uninsured group presumably to be projected by this law. Section (a)(3)(b)(2) should not be limited to 1985, but allow 1984 or earlier. Several cost containment states have already seen county support erode.

Specific technical information concerning the New Jersey payment mechanism for the uninsured has been made available to the subcommittee members and staff.

The steps we have outlined would increase our ability to provide uninsured individuals with access to needed health care and we are willing to work with the Federal government to identify other actions which we can take together to meet this challenge.

June 9, 1986
Sarah C. Shuptrine
Executive Assistant for Health and Human Services
Office of the Governor
State of South Carolina

I would like to express my appreciation for your invitation to present information on the South Carolina Medically Indigent Assistance Act which was signed into law effective July 1, 1985.

Governor Richard W. Riley and Representative Robert L. Helmly, Chairman of the Joint Legislative Health Care Planning and Oversight Committee, have worked diligently to maintain a partnership of effort between the public and private sectors in the development, passage and implementation of the Act. We believe this kind of cooperative effort is needed in order to build the consensus necessary to achieve passage of complex legislation and we have employed it on a number of occasions during Governor Riley's administration.

The Act was the culmination of several years of study. It has three major goals: 1.) To improve access to health care for poor citizens, primarily children; 2.) To reduce the cost shifting which was occurring due to the lack of a plan to compensate for the acute care needs of the indigent; and, 3.) To institute cost effective measures into the administration of the Medicaid program. There are a number of specific requirements which assure that the overall cost of health care is monitored and which establish an information base to provide policymakers and administrators adequate information needed for future decisions to assure that the Act is meeting its purpose.

Specifically, we raised our AFDC/Medicaid eligibility level from 27% of the federal poverty guidelines to 50%. We also created a statewide fund for inpatient hospital care for persons who cannot qualify for Medicaid and whose incomes are below 200% of poverty. All hospital costs for persons with incomes between 50% and 100% are fully covered by the Fund. Persons with incomes between 100% and 200% of poverty are required to assist in payment based on a sliding scale. The appendix to my remarks contains detailed information on eligibility, covered services and the funding mechanism.

The educational factor was integral to this effort and was of significant value in achieving support for passage. Most people in our State and in our Nation think that persons who have incomes below the poverty line are covered by programs like Medicaid. You know that this is not the case. There is no national minimum level of eligibility for poor families with children. As a result, the eligibility criteria for these vital national poverty programs varies from state to state producing a patchwork quilt effect rather than equal access to national services. There are approximately 35 states in this country which have AFDC/Medicaid eligibility levels below 50% of the poverty level.

Women, infants and children suffer the most from this lack of uniformity. We found in South Carolina that 43% of the indigent care admissions to hospitals were related to obstetrics, gynecology and pediatrics. This finding is significantly related to the indigent care issue, but far transcends it. By increasing the AFDC/Medicaid eligibility level, we have provided access to primary and preventive care resources for thousands of poor families, not just acute care. The cost of not providing for preventive services is substantial. Therefore, we view our action as being fiscally responsible and fiscally conservative. Prevention is, of course, the goal of the current effort in Congress to address the health needs of pregnant women and infants whose incomes are above a state's AFDC level but below 100% of poverty. Governor Riley has asked me to express the appreciation of the National Governors' Association and the Southern Governors' Association for your support of this initiative.

Who pays for indigent care? This is always the key question. In looking at the issue of equitable financing, it is important to recognize that when government fails in its responsibility to fund health services for the poor, payment for indigent care shifts to third party payors. And, in too many cases, care is not sought until the need is for acute care, thereby increasing the costs because preventive care was not accessible.

The financing of the South Carolina Medically Indigent Assistance Act achieves a fair and equitable cost sharing for indigent care. The State continues to provide all of the AFDC match and most of the Medicaid match and the federal government contributes its matching share for both the AFDC and Medicaid components. Counties contribute toward the Medicaid match and also fund half of the Medically Indigent Assistance Fund, which is the pool of funds that provides assistance for persons below 200% of poverty who are uninsured or underinsured. The other half of this Fund is provided by all general hospitals licensed by our State. With the cooperation of the S.C. Hospital Association and the S.C. Association of Counties, formulas were developed and incorporated into the Act which determine the amounts paid by each county and by each hospital. These contributions are provided quarterly. The actual eligibility determinations for the Fund are handled at the local level, but the eligibility guidelines are statewide.

In the first six months of our program, we have enrolled a net increase of 11,203 individuals in the AFDC/Medicaid program. We are working toward an estimated enrollment of 42,600 of which 25,000 are expected to be children. The Fund began on January 1, 1986 and was funded at $7.5 million for one half of this fiscal year. In the first four months, it has expended $4.7 million and we expect it to be exhausted by the end of the fiscal year on June 30. Next year it is funded at $15 million.

Some findings to date are:

1. The Medicaid Medically Needy Program has decreased by 22% since the AFDC/Medicaid expansion. This was, of course, part of the plan; and
2. 75.7% of the persons served by the Medically Indigent Assistance Fund have incomes below 100% of poverty (16.2% are children under age 18 and 59.4% were women). 20% of all claims were for pregnancies or newborn care.

We see future issues to be as follows:

1. Evaluation of the equity of the financing mechanism;
2. Evaluation of the eligibility process to assure statewide uniformity of application;
3. Development and evaluation of the cost containment mandates included in the Act;
4. Development of a plan to provide primary and preventive care, not just acute care, for South Carolina families between 50% and 100% of poverty; and
5. Assessment of eligibility criteria and covered services as they relate to appropriated funds.

Thank you once again for your interest in this initiative.

APPENDIX A

THE SOUTH CAROLINA MEDICALLY INDIGENT ASSISTANCE ACT

The South Carolina Medically Indigent Assistance Act was enacted as a permanent provision of the fiscal year 1985-86 General Appropriations Act. The funds were included in the base budget of two state agencies and will be reviewed annually as a part of the Appropriations Act.

Background

In early 1981, the Governor's Office convened a meeting of officials in the public and private sectors to begin to formally address the growing concern regarding the lack of access to health care for poor and low income citizens. It was decided that an initial study should be conducted to determine to scope of the problem and various financing alternatives. The results of the study indicated that Medicaid was a program that could be used to cover more people, primarily mothers and children, by increasing the eligibility criteria.

Following that report, the Chairman of the Joint Legislative Committee on Health Care Planning and Oversight, in conjunction with the House Medical

Affairs Committee, Senate Medical Affairs Committee, and the Governor's Office, agreed to lead the effort to investigate the issue further. A private consultant firm, the Toomey Company, was hired to further define the extent of the problem and to determine specific options available to the State.

During the interim the Governor proposed funding for a Medicaid Medically Needy Program for pregnant women and children. The legislature appropriated the State match and the Medically Needy Program began in October, 1984.

In the spring of 1984, the Joint Legislative Committee on Health Care Planning and Oversight appointed a small but diverse Ad Hoc Committee to consider all of the available information and make legislative recommendations. As a result, the Medically Indigent Assistance Act was drafted in the fall of 1984.

Description of Legislation

The Act was developed to accomplish four major goals: to increase access to medical care for poor and low income persons; to reduce the amount of cost shifting in hospitals due to charity care; to contain or avoid unnecessary costs; and to gather information for the future. Because of the breadth and scope of the Act, it addresses access, cost containment, financing, provider price information, health care competition and studies for future decisions. All sections of the Act were coordinated to in a single, consistent package.

Access to Care

The Act specifically and directly addresses financial access for poor and low income individuals who do not have resources to afford medical care. One of the eligibility criteria used for the AFDC and Medicaid programs is called the Standard of Need (maximum net income permitted). Ultimately a client's net income must be below the Standard of Need amount in order to qualify for benefits. The Act directed an increase in the Standard of Need establishing 50% of the federal poverty level as a standard for eligibility for AFDC and Medicaid. In specific terms, the eligibility level for a family of four was raised from 27% of poverty level ($2,748 annually) to 50% of poverty level ($5,328 annually).

The AFDC payment level, or monthly benefit award, remained relatively unchanged. Only the maximum net income permitted was increased. The payment level is 54% of the Standard of Need, which is a maximum of $238 per month for a family of four.

The Act further enhances expansion of AFDC/Medicaid by mandating establishment of an AFDC Unemployed Parent Program. Without such a program, poor intact families, who are otherwise eligible for programs, are denied assistance solely because spouses choose to live with each other. Implementation of this program eliminates a counterproductive policy of offering assistance only if families dissolve.

It is estimated that 42,600 individuals would be enrolled in AFDC and Medicaid as a result of adjusting the Standard of Need and implementing an AFDC-UP program. A major reason for expanding Medicaid is that this program allows coverage of preventive services and primary care benefits, which is particularly important to children and pregnant women. Services such as prenatal care provided early and continuously, reduce the likelihood of expensive neonatal tertiary care and infant death.

Beyond offering social and medical benefits to the extremely poor families through AFDC and Medicaid, the Act recognizes that many other low income persons experience financial hardships when confronted with the need for medical care, particularly hospitalization. Further, hospitalization, even for a short stay, can be financially disastrous for individuals who are uninsured, yet have the means to meet other daily needs. It is this group of persons, the uninsured and underinsured, who pose a financial hardship on hospitals providing charity care.

To alleviate this, the Act created the Medically Indigent Assistance Fund, which is a pool of dollars contributed by counties and hospitals for financing inpatient care needed by medically indigent individuals. The Fund is administered by the State to assure uniformity of eligibility criteria throughout the State. The Fund reimburses a hospital in full for delivering care to persons with incomes below 100% of the poverty level. For persons with incomes between 100% and 200% of that level, the fund pays only a part, which is based on a patients income in relation to the poverty level and size of the hospital bill. Resource requirements are statewide in application and are based on the AFDC/Medicaid resource requirements with some modification.

Another feature of the Act addressing access is an emergency care provision. The Act specifically prohibits denial of emergency care for a person, regardless of ability to pay or county of residence. The definition of emergency includes a woman in active labor.

Cost Containment

Major payors of health care are concerned about paying a fair rate and only paying for medically necessary services. Therefore, a major concern was to put into place incentives to shape provider behavior toward becoming more conscious of services delivery costs.

To accomplish this objective the Act mandates that the Medicaid hospital reimbursement system be converted from a retrospective payment system to a prospective payment system and that the same system be used for the Medically Indigent Assistance Fund. The prospective payment system replaces a cost based system that restricted recipient benefits to a maximum of 12 hospital days per year. It is viewed as a manageable and a fair method for reimbursing hospitals for services, because prospectively determined prices provide incentives for hospitals to be conscious of resource consumption and utilization.

Other cost containment and patient care methods are mandated. These include preadmission certification and utilization review, mandatory outpatient surgery, and a pilot program on second surgical opinions. Also, the Act directs implementation of procedures for encouraging the use of outpatient procedures.

The most controversial measure was the establishment of an annual target rate of increase for net inpatient charges for the hospital industry. If the industry exceeds this target rate, then standby regulation is triggered for review of those hospitals with unacceptable increases. Penalties can be applied after the second year of the Act.

Financing

Implementation of services and administration was budgeted at over $91 million for a 12 month period. Due to start up time, approximately $62 million was appropriated for services the first year. The AFDC/Medicaid component began on October 1, 1985 and the Medically Indigent Assistance Fund began on January 1, 1986.

Services are financed by four sources: federal draw down funds for matching AFDC and Medicaid; state funds as match for AFDC and Medicaid; counties; and, hospitals. The Act mandated that county governments contribute $5.5 million as their share of the Medicaid expansion.

The Medically Indigent Assistance Fund is financed by contributions from all county governments and all general acute care hospitals. The total contributions for each of the groups would be equal. The Fund was established at $7.5 million for the start up period of six months. Beginning the fiscal year 1986-1987 it will be annualized to $15 million.

Medically Indigent Services Budget
FY '86-87

	TOTAL	FEDERAL	STATE	COUNTY	HOSPITALS
AFDC	28,031,396	20,378,825	7,652,571		
MEDICAID	26,609,141	19,344,845	3,050,926	4,213,370	
MIAF	7,500,000			3,750,000	3,750,000
TOTAL	62,140,537	39,723,670	10,703,497	7,963,370	3,750,000

The Act sets forth an assessment formula for counties based on equal weighting of personal income, net taxable sales and property value. In the third and subsequent years, a fourth factor will be added to the formula to account for claims based on county of residence.

The assessment formula for each general hospital is its pro-rata share of the hospital industry's contribution, based on its prior year's ratio of total net to gross patient revenue, multiplied by the total number of patient days. Each hospital must contribute, regardless of whether it serves Medicaid or medically indigent patients.

The Act prohibits additional assessments against the State, counties or hospitals during the year if the fund is depleted. Should the Fund be exhausted, hospitals may resort to the old ways of doing business, that is, shifting the cost to other patients.

Provider Price Information

The Act prescribes a process to be followed for development of a system for collection and dissemination of cost and price data that is provider and diagnosis specific. The purpose is to have such information available to the public and to purchasers by 1987. This should serve to promote competition through consumer choice on the basis of the price.

Another area for promoting consumer choice is in the purchase of health insurance. The Competitive Model Task Force was formed in accordance with the Act to address this issue, as well as other issues that either stimulate or discourage competition.

Studies for Future Decisions

A number of studies are required by the Act to give policy makers information on a variety of aspects of the health care system. These studies include an examination of the State Employees Health Plan, a study of all individual and group health insurance plans offered in the state and an examination of requirements for implementation of a comprehensive health education program for the public schools.

Additionally, a comprehensive data base is to be established on the medically indigent population. This will provide the data needed to refine the definition of medically indigent as well as several program efforts initiated by the Act. One of the specific uses of the data base is to determine the extent of catastrophic medical expenses so that the issue can be addressed if the data indicate there is a problem.

Although entitled the Medically Indigent Assistance Act, the Act goes well beyond financing care for the uninsured. It sets out a framework for responsibly meeting the health care needs of the medically indigent and for looking into the future at the incentives and obstacles that block efficient operations of a health care system.

Policy Issues

AFDC/Medicaid Expansion

Many perceived, initially, that the AFDC/Medicaid expansion had a serious drawback, namely increasing welfare, when the primary effort was to increase access to medical care. However, information was available that was hard to ignore. According to the 1980 census, 16.6% of South Carolinians, or 500,363 persons had incomes below the federal poverty level. Children below the age of 18 comprised 39 % of this group. Of the one half million people living in poverty, the primary assistance program, AFDC, served only about one quarter. These numbers are significant since enrollment in AFDC entitles one to Medicaid coverage, yet not all poor families, and in particular poor children, were receiving benefits. The same is true for intact families. Until adoption of the AFDC-UP Program, zero income was not sufficient to entitle intact families to minimum benefits.

By raising the AFDC/Medicaid standard of need to 50% of the federal poverty level, the state not only improved access to health services for poor people, it provided cash assistance to help families meet basic needs such as housing, clothing, and food.

A key policy decision was South Carolina's decision to increase the AFDC/Medicaid Standard of Need (maximum net income permitted) while not significantly increasing the monthly benefits payment. The additional resources were used to increase the number of people eligible for existing benefits, not to increase the amount of benefits for existing eligible persons. This allowed the state to maximize its resources, since it could not afford to increase the Standard of Need and grant a corresponding increase in benefits payments. Therefore, the decision enabled the state to extend minimum AFDC benefits and full Medicaid coverage to a larger base population.

With all of the facts on the table, the AFDC/Medicaid approach represented a responsible method to address social and health care needs of a seriously impoverished population.

Cost Shifting

A 1981 study, published by the South Carolina Hospital Association found that hospitals marked up bills by 20% per day to recoup uncompensated care losses due to charity care. The Toomey Report found that in 1983, hospitals shifted $69 million from indigent or Medicaid patients to charge based patients. Another finding was that of the $69 million, $13 million was due to the Medicaid 12-day limit on hospital reimbursements.

The cost shifting issue had special significance as hospitals began to compete with one another for paying patients. Sixteen of 67 hospitals accounted for over 67% of uncollected charges and over 90% of charity care. Serving a disproportionate share of the medically indigent places such hospitals at a competitive disadvantage relative to hospitals that serve few if any indigent or Medicaid patients. It was particularly important to non-profit hospitals that the playing field be level; in other words, that hospitals refusing to care for the uninsured should not realize a competitive advantage.

A similar phenomenon was occurring among county governments. Of 46 counties, 8 were not contributing any funds toward hospitalization of their indigent residents. Of the 38 counties that annually made funds available for their residents, the allocations ranged from a low of $500 to a high of $5 million. Essentially some counties were getting a free ride by not assuming any responsibility for providing assistance to the uninsured sick. The impact of these decisions was evident when a number of hospitals, particularly the regional tertiary centers, enacted policies refusing admittance in non-emergency instances to unsponsored out of county patients.

The financing scheme for the Medically Indigent Assistance Fund serves as an equitable method of redistributing the financing burden of caring for the medically indigent under 200% of the poverty level. Pooling dollars contributed by counties and hospitals forces all counties to "pay for their own" in a manner that takes a county's financial capacity into account. Hospitals, regardless of their practices about serving the indigent, are mandated to contribute as well. This was viewed as a method of leveling the playing field. (It was recognized that mandating hospital contributions continued the practice of cost shifting; however, a required cost shift of $7.5 million for all hospitals is preferred to the $69 million cost shift concentrated among the hospitals that provided charity care.)

Cost Containment

Of all the cost containment measures written into the bill, two are of particular significance. One measure calls for altering the Medicaid payment system to a prospective payment system. Hospitals viewed a prospective price system as another method of leveling the playing field and one that would enhance competition among hospitals. Furthermore, the State leaders saw it as an approved method of paying for hospital care, in that the systems could be designed with incentive to discourage inappropriate resource consumption.

The most controversial measure was to give the State a non-regulatory method of red flagging the system if competition failed to decrease the rate of price increases. The method of establishing a target rate of increase for net inpatient charges was devised. If the hospital industry exceeded that rate, stand by regulations will be triggered. The Governor felt strongly that this was necessary to assure the public that tax dollars in support of the Act were not merely increasing the bottom line of hospital budgets.

Responsibilities

The Medically Indigent Assistance Act redefined which level of government is responsible for providing health care for poor and low income citizens. The financing scheme reflects the State's position that indigent care is such a large and important issue that no single level of government should assume it totally. Therefore, federal, State and county resources must be utilized together to implement a comprehensive Statewide program under State administration. State administration provides for flexibility in management as well as uniformity in equity across all counties.

The contributions by hospitals to a State administered pool for reimbursement to hospitals for medical care rendered, is an essential means to financing indigent care. It assures that all citizens have access to care regardless of county of residence. No hospital is placed at a competitive disadvantage because it provides indigent care, and the issues of cost shifting and access become public policy issues, not hospital budget issues.

Disadvantages or Shortcomings of the Design

As it is currently functioning, the state's approach to health care for the poor is incomplete. Financial assistance for primary care is not provided through the Medically Indigent Assistance Fund. Our reliance on federal and state programs which focus on special diseases or populations creates inequities. Further, the Medically Indigent Assistance Fund and the Medicaid Medically Needy Program do not provide for continuous eligibility, leaving gaps in access and availability of services which are particularly harmful to children and pregnant women.

The state administers the program policy and payment operation of the fund. It depends on each county government to designate who determines eligibility on the local level. In most cases, either the hospital or a county office is designated. This function relies on reallocation of funds for staff resources at the local level. Thus, accountability of eligibility administration is not directly tied to the State. The full impact of this decision is not known and will be evaluated after sufficient experience with the program.

AFDC/MEDICAID EXPANSION

One of the major initiatives of the Medically Indigent Assistance Act (MIAA) was to expand the Aid to Families With Dependent Children (AFDC) program. The AFDC expansion was intended to impact accessibility to health care by providing AFDC/Medicaid benefits to an additional 42,600 needy citizens of the State. Effective October 1, 1985, the AFDC program was expanded by:

- o Increasing the AFDC standard of need to fifty (50) percent of the federal poverty guidelines; and
- o Implementing the AFDC - Unemployed Parent program.

In order to ensure that individuals were aware of the existence of the new program standards, the following outreach activities were conducted:

- o Public service announcements were made.
- o Notices were mailed to all food stamp recipients.
- o Medical providers were informed of general program guidelines.
- o Local newspapers published articles about the program.
- o Information brochures were developed and distributed.

Although the number of eligibles has not increased as rapidly as expected, the AFDC population has grown by approximately 11,600 recipients in the first nine (9) months of implementation of the revised standards. Some of the increase in the AFDC population is due to a shift from the medically needy program. The medically needy rolls have decreased 22 percent since the AFDC expansion was implemented. The remaining medically needy recipients utilize medical services at a higher rate than other users. The average Medicaid expenditure for a medically needy recipient is $660.00 per month as compared to that of $297.00 per month for other Medicaid users excluding institutionalized individuals. In future years, it is anticipated that the medically needy program will become more of a catastrophic illness program.

During the same nine (9) month period, the AFDC - Unemployed Parent program grew from 0 to 1736 eligibles. The relatively slow growth rate in the number of AFDC - Unemployed Parent eligibles may be partially attributed to the regulatory restrictions regarding the individual's relationship to the work force and to the continuing reduction in South Carolina's unemployment rate. The State's current unemployment rate is 6.8 percent.

It should also be noted that experience with the implementation of other new Medicaid coverage groups indicates that it takes nearly two years for the recipient population to reach its expected level.

MEDICALLY INDIGENT ASSISTANCE FUND

Another major initiative, the creation of the Medically Indigent Assistance Fund (MIAF), was implemented effective January 1, 1986. The purpose of the MIAF is to provide inpatient hospital services to persons who do not have sufficient means to pay for needed medical care. The MIAF covers inpatient hospital services consistent with those provided by the South Carolina Medicaid Program.

A single state agency was designated the responsibility of developing uniform criteria and materials which are used statewide to determine eligibility for the MIAF. County governments were assigned the responsibility of arranging for the administration of the MIAF at the local level. In other words, each county government was required to arrange for a representative (i.e. County Designee) to determine eligibility for their county residents. The majority of county designees are employees of local hospitals or the county government. Many county designees had little or no experience in determining eligibility for an assistance program. Because the backgrounds and job descriptions of the county designees are so varied, program policies are not always applied consistently throughout the State.

One result in the variation in program administration at the local level is that accessibility to health care may be impacted. If an individual applies in a county which follows the rules of the program, he may be determined ineligible for assistance. However, if he were a resident of a county which ignores many of the rules of the program, he may be determined eligible for assistance. Problems related to the diversity in administration at the local level have been and continue to be the most difficult to resolve. The single state agency responsible for administration of the MIAF has no enforcement authority over the counties' activities.

The MIAF will be exhausted prior to the end of the fiscal year. Therefore, an analysis of currently available data will be completed to determine what if any program changes need to be made. Changes which may need to be considered are changes in eligibility policies or service coverage. The data will also be used to determine if revisions to the existing Medicaid Program would be beneficial to the State's citizens.

To date the MIAF has served 3,369 persons. The following tables provide information pertaining to the characteristics of the recipients served and their medical problems. Table I describes the ten (10) most common diagnostic related groupings which were processed through the MIAF Claims Payment System. Table II provides information about the recipients served. As Table II indicates, 16.2 percent of the recipients served were children under age 18 and 83.8 percent were persons age 18 and older. The percentage of females served was 59.4 percent as compared to 40.6 percent males. Most of the persons (75.7 percent) who received assistance through the MIAF had income equal to or below 100 percent of poverty while 24.3 percent had gross annual income between 100 and 200 percent of poverty. Twenty percent of all claims paid were pregnancies or newborn care related.

TABLE I
Medically Indigent Assistance Fund
Ten Most Common DRG Codes
June 4, 1986

	Code	Description	Percentage of Claims
1.	391	Normal newborns	5.9%
2.	373	Vaginal delivery w/o complications	5.3%
3.	355	Non-radical hysterectomy, age - 70 w/o cc	1.9%
4.	183	Esophogitis, gastroent, misc. digestive disorders	1.8%
5.	204	Disorders of the pancreas, except malignancy	1.8%
6.	89	Simple pneumonia-pleurisy, age - 69 and/or cc	1.5%
7.	14	Specific cerebrovascular, disorders except tia	1.5%
8.	430	Psychoses	1.4%
9.	368	Infections of the femal reproductive system	1.4%
10.	127	Heart failure - shock	1.3%

TABLE II
Medically Indigent Assistance Fund
June 4, 1986

Total unduplicated claims processed and paid = 3,369

Recipient Age	
Under 18	16.2%
18 and older	83.8%
Recipient Sex	
Female	59.4%
Male	40.6%
Recipient Income Level	
Poverty level or below	75.7%
100-200% of poverty level	24.3%
DRG Type	
Pregnancy related	11.0%
Newborn related	8.0%
Other	81.0%

COST CONTAINMENT MEASURES

The Medically Indigent Assistance Act mandated five (5) cost containment measures for the Medicaid Program. The cost containment measures are identified and described below:

- Mandatory Ambulatory Surgical Program -
  A list of 274 surgical procedures developed by the South Carolina Medical Association was adopted as mandatory outpatient surgery procedures. These are procedures which physicians felt comfortable performing in an outpatient/ambulatory setting, barring any contraindication. Contraindications include the need for general anesthesia, presence of other medical conditions which might lead to complications, minor surgery being performed at the same time or likely to be preceded by major surgery, absence of adequate post operative home care, etc. The feasibility of expanding the list to include cataract surgery and other procedures will be explored in the upcoming months.

- Pre-admission Certification -
  This provision requires that physicians obtain pre-admission certification for certain elective surgical procedures prior to hospital admission. Six (6) procedures for which the method of treatment varies significantly among practitioners, within the State and nationally, were selected. Studies have shown that the tendency to perform hysterectomies with the presence of certain similar medical conditions vary as much as 70 fold. Hysterectomy is one of the six procedures selected for preadmission certification. The other procedures are: D & C, tonsillectomy, herniaorphy, cholesectomy and orthoscopic knee surgery. Performance data will be evaluated to determine if the pre-admission certification list needs to be revised.

- Second Surgical Opinion Pilot Project -
  A second surgical opinion is required for those procedures for which pre-admission certification for medical necessity is denied. This allows the second surgical opinion to augment the pre-admission certification program. The effectiveness of this approach will be evaluated.

- Enhanced Utilization Review -
  The utilization review criteria was changed from a review of randomly selected elective admissions to a targeted review. The initial targeting requires a 100 percent review of all procedures on the ambulatory surgical list, providing the pre-admission certification, reviewing the second surgical opinion, validating diagnoses to ensure correct grouping to the Diagnostic Related Groupings and sample reviews of day and cost outliers under the prospective payment system. Institutions and practitioners who have several denials are targeted for a more intense review. The focus of utilization review activities will be revised as data indicates areas of potential misutilization.

- Incentives for Outpatient Ambulatory Services -
  Hospitals were provided with a financial incentive to treat patients in an outpatient setting by increasing reimbursement from 69 percent of the cost to charge ratio to 100 percent. Physicians were offered financial incentives to treat patients in their offices by reimbursing additional amounts for treatment rendered after hours, on weekends and holidays, and reimbursing the cost of a surgical tray at actual charges up to $30.00.

Each of these measures was implemented effective January 1, 1986. While it is too early to determine the effectiveness of these measures, they have impacted utilization and the location in which procedures are being performed. This is documented by the number of denial notices received from the utilization review contractor. A method of evaluation is being developed to evaluate the effectiveness of these cost containment measures. Because the measures are interrelated, it may be necessary to evaluate the measures as a whole rather than individually.

PROSPECTIVE PAYMENT SYSTEM

The requirement of the Medically Indigent Assistance Act to implement a prospective payment system (PPS) was implemented effective January 1, 1986 with an interim system. The interim system is based on the Medicare DRG system with Medicaid weights for discharges calculated based on weights in four (4) states which have similar PPS'. The basic system attempts to reimburse for the cost of care provided in an efficiently run facility.

It is based on hospitals' fiscal year 1983 cost reports inflated forward to the present based on Data Resources Inc. (DRI's) inflation index. Adjustments were made to the cost base to compensate for the Cost of Care in excess of 12 days(1). Reductions to the cost base were made for increased productivity (1%), coding improvements (6.2%) and a reserve for outliers (5%). The interim PPS does not reimburse hospitals in excess of what they receive under Medicare. Furthermore, it is believed that the system reimburses hospitals slightly less than would be reimbursed under a cost related system and offers incentives for efficient operations.

The interim PPS will be replaced in October 1986 with a Hybrid PPS that is South Carolina specific and addresses the numerous policy issues not adequately addressed by the interim system.

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(1) S.C. Medicaid limited inpatient hospital care to 12 days during 1983. Hence the Cost of Care over 12 days is not included in the 1983 cost reports.

Chairman STARK. Thank you.

Returning to South Carolina for a minute, in a general sense and not in a technical sense, because I haven't had a chance to read all your rules, how would the proposed bill affect your program? Would you qualify——

Ms. SHUPTRINE. I have not had a chance to review the proposed bill in light of how it applies. I am going to do that after this hearing.

Chairman STARK. OK, because that has been suggested in previous panels that when we start a mandated Federal program in an area where we have 50 different sets of rules, it is a problem. New Jersey, what would happen in New Jersey?

Ms. GRANT. The two provisions concerning Hill-Burton and the underinsured Medicare beneficiary would give us particular problems as would the lack of clarity as to whether the prospective notion of case mix methods to be an appropriate basis for paying.

The language speaks to reasonable and customary and we view ourselves as moving beyond that to a prospective cost containment, so we would need clarification there.

[The following was subsequently received:]

State of New Jersey
DEPARTMENT OF HEALTH
JOHN FITCH PLAZA
CN 360, TRENTON, N.J. 08625

J. RICHARD GOLDSTEIN, M.D.
COMMISSIONER

SUBCOMMITTEE ON
RECEIVED
JUL 10 1986
HEALTH

July 1, 1986

Fortney H. Stark
Chairman
Committee On Ways & Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman Stark:

Thank you for the opportunity to testify for the Subcommittee on Health concerning your bill H.R. 4742. "The Health Care Improved Access Act of 1986."

You addressed a question to witnesseses concerning the availability of private insurance with open enrollment and insurance regardless of health status provisions. In answer, I am attaching a copy of a statement provided me by New Jersey Blue Cross/Blue Shield. That insurer has long had a policy of open enrollment regardless of health status in New Jersey. I commend this statement to you and your staff's attention.

We hope that a careful evaluation of all testimony will lead to the conclusion that because the problems of the uninsured are so serious the recent federal cutbacks in commitment to Medicare and Medicaid make inappropriate the simple transfer of this responsibility to the states under a Federal mandate.

Sincerely,

Chris Grant

Christine M. Grant, Esq.
Director
Hospital Reimbursement Program

CMG:ri
Enclosure

cc: M. J. Coye, M.D.
J. Morris
H. Shapiro

New Jersey is an Equal Opportunity Employer

Blue Cross and Blue Shield of New Jersey has had a continuous policy of open enrollment since the introduction of the Hospital Service Co-Op Protection Plan and Medical Services Special Series Programs in 1978.

Under these programs, any person applying for Hospital, Medical Surgical, Rider J and Major Medical coverage will not be turned down for reasons of health. As with our regular individual contracts, benefits will be excluded for treatment of pre-existing conditions for one year from the date of enrollment.

Under the Hospital Service Co-Op Protection Plan, a person with health problems will pay the same rate for coverage as those with a clean bill of health. There is a copayment requirement placed on all Co-Op Plan enrollees. In the case of an inpatient admission to a member hospital or residential care facility, the copayment will be $50 for the first day and $20 per day for the second through tenth days. The maximum copayment for an inpatient admission is $230 and the total copayments for all family members will not exceed $460 per benefit year. The hospital copayment requirement will be eliminated after five years of enrollment at which time the subscriber can have regular Comprehensive Blue Cross coverage.

In the case of Medical-Surgical Special Series Programs, a subscriber will receive the same coverage as those meeting health requirements, but will pay a slightly higher rate for this coverage. Participating physicians will accept the Special Series allowances as payment-in-full provided the subscriber meets income eligibility guidelines. If the subscriber exceeds the maximum allowable income, they will be responsible for any difference between the allotment for an eligible service and the actual doctor's charges. After a subscriber has been enrolled for five years, he will be charged the same rate as that paid by regular individual subscribers.

Major Medical is available to anyone who is enrolled for coverage in Blue Cross and Blue Shield basic programs and, has Rider J, unless they are Medicare eligible or have Student Coverage. Any person who does not qualify for Major Medical with a $200 deductible due to existing health conditions, will be assigned Major Medical with a $500 deductible. This coverage will pay 80% of the Usual, Customary and Reasonable charges for covered expenses after the annual deductible has been met.

Only those people who are 65 or older and/or Medicare eligible can not qualify for Basic and Major Medical Benefits. Anyone wishing coverage who is Medicare eligible can apply for Medicare Supplementary Benefits. We offer three types of Supplementary Coverage: Medicare Complimentary, Select or new Super 65, which can be purchased to strengthen the Medicare coverage.

For more information on covered services or any questions regarding the coverages offered by Blue Cross and Blue Shield of New Jersey our Service Centers are located at: Florham Park, (201) 966-0880; Paramus, (201) 368-9661; Princeton (609) 452-8100; Cherry Hill, (609) 424-8220.

Sister **Geary**. Massachusetts has a plan. We have determined that 10 percent of our care is uncompensated and in our State we have a program whereby in my hospital if it were 7 percent, I would keep the 7 percent and pay 3 percent into a State pool. A hospital that might have 20 percent would get 10 percent from the pool.

Mr. **Vladeck**. I think the experience in a number of States over the last few years has been that the problem is less one of 50 State plans, but of the enactment by Congress, at the behest of this committee, of legislation which the executive branch may not care for, so they impede the implementation process. I think that might argue for more specificity in this legislation than you might deduce from a civic textbook.

Chairman **Stark**. It is difficult to write legislation to be enforced by somebody who doesn't want to enforce it. That is like carrying water in your hands. It is difficult.

I guess one of the things that I keep thinking about is the mobility question. It seems to me that if the benefits are uniform, you don't run into the question of people here moving from Virginia to Maryland because one program is better or more or less expensive in Maryland than Virginia, thus, giving us headaches. If somebody makes an adjustment, they find people who will sign up. I haven't focused on that.

I appreciate you all joining with us today, and I know we will be seeking your counsel and your suggestions as we attempt to put this complicated measure together.

Our final panel comes from the business community, and we are honored to have William Edwards, the director of Employee Benefits and Services of the WestPoint Pepperell Corp. of West Point, GA, representing the National Association of Manufacturers, accompanied by Sharon Canner; and James A. Klein, manager of pension and employee benefits of the U.S. Chamber of Commerce.

Mr. **Klein**. Our witness will be Richard Fay, chairman of the Employee Benefits Council.

Chairman **Stark**. Would you like to go ahead.

Let me suggest, I have had a chance to review your written testimony, which you so generously have provided us ahead of time. I think it is fair to suggest that these two groups have some serious problems with our bill.

I am sure you share our concerns, as your testimony indicates, so perhaps I could stipulate that both the U.S. Chamber of Commerce and the National Association of Manufacturers have a deep concern for the problem of the uninsured and uncompensated care, but that their membership find that perhaps the approach we are taking in this bill creates some problems and we could get you to focus in on your expanded testimony on what those problems are and what we might do to change them other than wait to correct them.

So with that, I will attempt to prod the witnesses.

Mr. Edwards.

STATEMENT OF WILLIAM V. EDWARDS, DIRECTOR, EMPLOYEE BENEFITS AND SERVICES, WESTPOINT PEPPERELL, WEST POINT, GA, REPRESENTING THE NATIONAL ASSOCIATION OF MANUFACTURERS, ACCOMPANIED BY SHARON CANNER, DIRECTOR OF EMPLOYEE BENEFITS

Mr. EDWARDS. I am William V. Edwards, director of employee benefits and services, WestPoint Pepperell, Incorporated, located in WestPoint, GA. Today I am appearing in my capacity as a member of National Association of Manufacturer's Employee Benefits Committee. Accompanying me is Sharon Canner, NAM director of employee benefits. The NAM is an organization of over 13,000 corporations located in every State. Members range in size from the very large to over 9,000 smaller manufacturing firms, each with an employee base of less than 500. We are pleased to be here to present our position on the Access to Health Care Act of 1986 (H.R. 4742).

Mr. Chairman, we share your concerns with the problems of care for the medically indigent. Indeed, the NAM encourages its members to voluntarily provide various types of assistance as proposed under H.R. 4742. However, certain provisions of the "Access to Health Care Act of 1986," would interfere with State and local programs now in place and further discourage the expansion of employment-based health insurance, the source of protection for over 85 percent of American workers and their families. Therefore, we cannot support this legislation.

We believe health care for the poor and the uninsured is a multifaceted problem demanding a variety of creative, thoughtful, and fiscally responsible approaches. Various initiatives responding to this problem are already underway.

For example, many employers extend health insurance coverage to laid-off workers and their families. My company, WestPoint Pepperell, extends health care benefits, dental care, life insurance and other employee benefits to laid-off employees up to 12 months.

We share your concerns with the problems of care for the medically indigent. NAM has encouraged its members to voluntarily provide various types of assistance as provided under the act. However, certain provisions of the act will discourage the expansion of employer-based health insurance.

The extension of employer-based health insurance for laid-off workers for 4 months is a particularly onerous requirement for us.

The ink is not yet dry on the Consolidated Omnibus Budget Reconciliation Act of 1986, better known as COBRA, which requires 18 months of coverage, and yet new legislation is being proposed. This is a duplicative, complex and confusing burden for employers to provide health coverage to their workers.

In the morning, I am meeting with a group from my own company to try to assess how we as a company go about implementing COBRA. We have people represented from our personnel systems, from our communications department, claims processing, and from our legal staff to try to sort out all the various questions that we do not know the answers to.

We are struggling with the questions of coverage and with the question of exactly what premium can be charged, 102 percent of what.

We are worried about the interface with HMO's, PPO's and preadmission review. We feel that we need time to assess COBRA, the effects and problems.

The area that will be hardest hit by the proposals would be small business, and this is the greatest source of job creation in this country. In my company, the cost to provide 100 employees medical insurance for 4 months is approximately $40,000. We have to weave and sell a lot of towels to net $40,000.

We are also struggling to compete in world markets, and this cost is a significant one for us.

Finally, we commend the provisions of the proposal that include tax incentives for the self-employed to provide health insurance to their employees. We also support demonstration grants, encourage insurance coverage for small firms.

In conclusion, we know that this is a highly complex area, requiring much study, creativity and discussion. We appreciate our opportunity to comment on the deliberations.

Chairman **Stark**. Let me go back to the numbers. You say 100 employees for 4 months is $40,000. Am I to assume that your cost is $100 per employee per month?

Mr. **Edwards**. That is correct.

Chairman **Stark**. You are paying the whole thing; there is no employee contribution?

Mr. **Edwards**. This is our portion of the cost for my company.

Chairman **Stark**. OK. Well, that is reasonable. I am not sure that that is what the cost would be. Doesn't it seem more reasonable to assume that if you must provide that—are you self-insured?

Mr. **Edwards**. We are self-insuring.

Chairman **Stark**. I would think even there whoever writes your plan, it would be more logical to assume that over a period of years you would build up a reserve.

Mr. **Edwards**. We are self-administered, sir.

Chairman **Stark**. My guess is that that is not a fair accounting analysis——

Mr. **Edwards**. Those are actual figures.

Chairman **Stark**. I understand they are the actual figures if the event took place.

Mr. **Edwards**. If the event took place.

Chairman **Stark**. So therefore, there is some actuarial cost to that in present dollars so it might not be fair to say that this is going to cost you $40,000 a year every year, is it, for those 100? Once you have the 40,000 bucks set aside, you are home free, aren't you?

Mr. **Edwards**. That would be correct, and of course it would be in increments of 100 employees.

Chairman **Stark**. I understand that.

Mr. **Fay**. I will take your suggestion and just give you the essence of our statement.

Chairman **Stark**. Mr. Fay.

STATEMENT OF RICHARD H. FAY, CHAIRMAN, EMPLOYEE BENEFITS COUNCIL, U.S. CHAMBER OF COMMERCE, ACCOMPANIED BY JAMES A. KLEIN, MANAGER, PENSION AND EMPLOYEE BENEFITS

Mr. **Fay**. Thank you for acknowledging our concern about this very important problem.

Our comments will be very general, but we have established a task force to look into your bill and to look into its impact and to perhaps give you more specific comments. We look forward to the opportunity to work with you and members of your staff. However, as you suggested, we are somewhat concerned by the bill.

First, I think you should realize that the private system is a successful system. It is an expensive system, and it provides a great deal of benefits to the average American and one should not assume that progress is inevitable.

It is possible to go back as well as forward, and our concern with this bill is that it places a disproportionate burden on the employer who is already providing benefits, and will result in reduced benefits for some of his remaining employees and it creates disincentives for employers without these plans to establish them.

That is the essence of our comment, that maybe this bill is not going to be as beneficial as one would hope, and it is a disservice to those employers who have established such coverage.

A couple other general comments on the subsidized insurance pools. This may well be an appropriate device in certain places, but again we are troubled by the mandated quality of it.

We support that aspect of your bill which provides a tax incentive for the self-employed. We note that it is already in the Senate-passed bill.

Chairman **Stark**. Just out of curiosity, on some of these, for instance, on the risk assignment plans, do your members, both of you, in the States where they already exist, are you getting complaints there? Does anybody know?

Mr. **Klein**. Not particularly, but we haven't heard one way or the other from people.

Chairman **Stark**. My point is that some of this is going on and I would be interested to know——

Ms. **Canner**. We have heard, most of the companies I have heard from are the self-insured companies, so it doesn't——

Chairman **Stark**. You haven't recorded it?

Ms. **Canner**. But the small businesses are calling us about COBRA and problems with that.

Mr. **Fay**. I know we don't want delay, but we do have a law that addresses some of the same concerns.

It would be useful, I think, to see how this new law is implemented and the costs and the problems associated with it. It might be a very good education for what is proposed in this bill.

The last point we want to make, again following our prepared document that we support your concept of demonstration grants for lowering health costs, particularly for the small businessman, because we see that as the area of greatest need. We see the area of greatest need as coverage, frankly, for active employees.

Thank you very much.

Chairman **Stark**. Thank you.

[The prepared statement follows:]

STATEMENT
on
"THE HEALTH CARE IMPROVED ACCESS ACT OF 1986" (H.R. 4742)
before the
SUBCOMMITTEE ON HEALTH
of the
HOUSE COMMITTEE ON WAYS AND MEANS
for the
U.S. CHAMBER OF COMMERCE
by
Richard H. Fay
June 9, 1986

Mr. Chairman and members of the Subcommittee, my name is Richard H. Fay. I am a partner in the law firm of Reed Smith Shaw & McClay and Chairman of the U.S. Chamber of Commerce's Employee Benefits Council. Accompanying me today is James A. Klein, the Chamber's Manager of Pension and Employee Benefits.

I am pleased to testify on behalf of the Chamber on H.R. 4742, "The "Health Care Improved Access Act of 1986." The goal of improved health-care delivery is an important one for the nation, and the Chamber shares the Subcommittee's interest in this matter. Toward this end, the Chamber's Health Care Council has established various task forces on retiree health care and on uncompensated care in order to study more thoroughly this matter and to assist public policy decision-making in this area.

In brief, the Chamber supports the present system of voluntary, nondiscriminatory, private-sector employee health care benefit plans which can vary in accordance with the needs of employers and employees. The Chamber opposes federal or state government requirements mandating plan design or financing, whether applicable to insured or self-insured plans, because they limit flexibility and raise costs. Furthermore, if Congress decides to embark on the major change in policy that mandated benefits would represent, fairness to all affected parties demands that there first be a thorough policy debate, similar to the one preceding enactment of federal restrictions on retirement plans.

SUCCESS OF PRIVATE HEALTH-CARE BENEFITS

Health-care benefits are a valuable and enormously successful protection for workers and their families. Voluntary health plans have the flexibility to meet the needs of workers within the total compensation resources of their employers. The federal government has been vital to the success of this private-sector approach, through providing broad tax incentives for employers to provide group health-care benefit plans for their employees without dictating the terms of these plans.

Employers currently spend an estimated $100 billion each year on health care for their employees. As health-care costs have risen over the past decade, business, as the purchaser of health care on behalf of most working-age Americans and their dependents, has taken an active role in the redesign of health-insurance plans to assure the efficient delivery of quality care. Central to these efforts has been the stimulation of competition in providing health care, by offering workers choices of delivery systems.

I now wish to direct my remarks to the provisions of H.R. 4742. There are elements that the Chamber supports, and others that it opposes.

EXTENSION OF HEALTH COVERAGE FOR FORMER WORKERS

Only two months ago, Congress enacted -- and the President signed into law -- the Consolidated Budget Reconciliation Act of 1985 (COBRA), which contained provisions requiring employers to continue to make available health-care plans to various categories of former employees and their family members (at the individual's own expense) for periods ranging from 18 to 36 months. Those continuation of coverage requirements were attached to the budget measure with little open Congressional discussion or debate. At the time COBRA was being considered, the Chamber and others noted that such continuation of coverage requirements would be administratively costly and would be a forerunner of mandating health-care coverage directly at the employer's expense. We did not realize how prescient we were.

Before the relevant provisions of COBRA even have gone into effect and before any guidelines or regulations have been issued telling employers how to comply with the new, unwarranted requirements of COBRA, a new proposal, H.R. 4742, has been introduced, which would require employers to pay for benefits for up to four months for former employees and their families.

In light of the rapid progression of increasingly greater mandates in just the past few months, the Chamber submits that the four-month coverage requirement of H.R. 4742 would be just the beginning -- with greater and more costly mandates to follow.

As superficially appealing as requiring health-care coverage for former employees may seem, such a mandate does come at a great cost to the voluntary employee benefits system. It provides a great disincentive for employers to offer health insurance to employees at all.

Many employers continue coverage or permit health-insurance conversion opportunities for former employees. The Chamber applauds those employers that are able to afford and do provide continuation coverage, but the fact is that often employees are terminated due to adverse business circumstances that necessitate work force reductions. If employers are faced with the prospect of health-care expenses for former employees, they will offer either less generous health plans or higher copayments and deductibles or, in the extreme, offer no health-care coverage. Alternatively, employers may offer fewer other benefits to terminated employees, such as severance benefits or job relocation or retraining services. Other employee benefits for all workers may be curtailed in order to keep overall compensation costs affordable.

The prospect of paying for continued health coverage for the spouse of a former employee when that spouse may be eligible for coverage from his or her own employer and for employees who voluntarily quit work is especially onerous. These types of requirements will certainly be a disincentive for employers to establish or retain health-care benefits.

Obviously, no reliable data yet exist on the number of companies that will curtail or abandon health or other employee benefits as a result of the continuation of coverage requirements of COBRA. However, on an anecdotal basis, the Chamber can confirm that numerous employers are outraged by these mandates, and have stated that they are considering reducing the benefits they offer to employees. Faced with the mandates of H.R. 4742, which involve an even greater direct cost to employers, the abolition of benefit plans could be enormous, and that certainly would not inure to the benefit of either employed or unemployed workers.

According to the Chamber's 1984 Employee Benefits Survey, employers already dedicate nearly 37% of compensation costs to all types of employee benefits, including legally required as well as voluntarily provided benefits. Mandating a new benefit would not increase necessarily the overall employee benefits "pie" but only would cut the pieces of the pie smaller as employers cope with a new costly federal requirement.

SUBSIDIZED INSURANCE POOLS

The Chamber is studying carefully the "insurance risk pool" concept and has not yet taken a formal position on risk pools. Health coverage for the medically uninsurable population is important, but the mandatory risk pools concept presents certain concerns. The extent of the problem of the medically uninsurable population varies throughout the country, and risk pools may not be an appropriate response in all instances.

Since the risk pool participants will be individuals with a high likelihood of incurring expensive health-care costs, the premium they pay (i.e., 150% of the cost of individual health insurance) almost certainly will not be sufficient to pay for the actual expense of providing coverage. As a result, under H.R. 4742, those businesses providing health-care coverage, both self-insured and those purchasing group insurance, will have to pay for any shortfall in the pool. Paradoxically, those companies that are providing health benefits to their employees also will be incurring an unknown and limitless risk for paying for health-care coverage for other individuals -- some of whom may be the employees of their competitors. In that environment, there would be a much-reduced incentive for employers to establish or keep a health-benefits program.

The risk pool concept and its effectiveness in the nine states that currently have the pools, need to be scrutinized carefully. An incentive for establishing risk pools may ameliorate part of the uninsured health-care problem. But, mandating risk pools — just like mandatory benefits, generally — is no universal panacea.

TAX INCENTIVES FOR THE SELF-EMPLOYED

The Chamber applauds the provision of H.R. 4742 allowing a business tax deduction for the health-care coverage purchased for self-employed individuals. The Chamber has stated previously its support for this proposal, which treats the self-employed more equitably. This change will help ensure greater health-care coverage for the self-employed and, in turn, more likely will result in health-care coverage for the employees of self-employed individuals.

The Chamber is pleased that the Senate version of the tax reform act, H.R. 3838, similarly allows for a tax deduction for the self-employed and urges members of the Ways and Means Committee to support that aspect of the Senate tax measure when it is considered in conference.

DEMONSTRATIONS ON LOWERING THE COST OF HEALTH CARE TO SMALL BUSINESS

The Chamber also commends you, Mr. Chairman, for recommending that demonstration projects on ways to lower health-care costs for small businesses be encouraged. Traditionally, lack of coverage is greatest among smaller companies, due to their diminished ability to pay for and administer employee-benefits programs.

The U.S. Chamber's affiliated "Clearinghouse on Business Coalitions for Health Action" has been active in advising small firms on ways to provide health care in the most comprehensive and efficient manner. In addition, a number of state and local chambers of commerce have embarked upon innovative programs to show small businesses how they can afford to offer health-care coverage to their employees. The Chamber is gratified that the authors of H.R. 4742 have recognized this excellent work by proposing demonstration grants and recommending that chambers of commerce be among the types of organizations to receive such grants.

CONCLUSION

The issue of uncompensated care is varied and complex. The business community must play a role in addressing the issue, but should not be looked to alone to finance proposed solutions.

Imposing health-coverage mandates — either in the form of continuation of coverage for former employees or in the form of mandatory risk pools — actually may force some employers to diminish or eliminate their health-care plans or other types of employee-benefit coverage, to the detriment of all Americans.

In short, the Chamber believes mandates generally penalize the employer who already provides coverage. They do not address the more fundamental issue of how to provide incentives for those who do not or are unable to provide coverage.

Chairman STARK. I see we are batting 250—I gather that with some reluctance the tax—the tax deductibility makes the small business one voluntary, so you really don't care about that, and it makes it cheaper for somebody to provide medical insurance to their employees, so that—am I getting agreement that that is OK with both groups?

Mr. EDWARDS. Yes.

Mr. FAY. Yes.

Chairman STARK. How about the risk pooling? It would seem to me that that has to lower your costs.

Mr. EDWARDS. Can I comment on that briefly? That is one thing that I did leave out of my testimony.

My own company does not operate primarily in some of the States that have risk pools, but on balance, it does not appear to us to be a prudent thing to do.

We feel like the people that are in the pools would be those that would be at the highest risk; it would be people that would have the least incentive to make cost-effective decisions.

It could be even a disincentive for some employers to offer health insurance, and that has been spoken to several times earlier today.

Chairman STARK. The evidence that was presented here by the people in the communities didn't seem to indicate that. It was an incentive for other insurance companies to quit offering it. And they would.

But that seems to me to be the point. I think that what they are talking about is diabetes, pre-existing conditions, epileptics, who for one reason or another, if you cover them in your plans, it raises your cost. If that risk is shared more broadly, I think your costs would go down. I will note that you don't feel that way. Go ahead.

Mr. KLEIN. I was going to note, perhaps just to echo the previous point made, that I understand the rationale but the concern is that essentially if the pool will be comprised of these medically high-risk people, the 150 percent maximum premium would not be sufficient to cover what would be their true experience rating, and then the employers that already provide coverage would be looked to to make up any shortfall.

Chairman STARK. Suppose we put in effect the same kind of tax system that we use for unemployment compensation, which seems to me actually to be fairer. It is broader based and therefore less of a burden on selected groups.

Mr. KLEIN. Without endorsing that, obviously——

Chairman STARK. Does it look like a lesser evil to you?

Mr. KLEIN. This is an important societal goal that we want to address. It doesn't seem quite right or proper or efficient really to ask those employers that are already taking the initiative in a voluntary system to provide coverage to pick up the tab for this important goal.

Mr. FAY. I would like to echo that. That is the fundamental question about this proposal.

Chairman STARK. Then who should? Let's look at it another way.

Mr. FAY. That is philosophical. If that is a societal need and a legitimate one, then the traditional way of handling it, and I think the sound way, is by general taxation.

I think there is too much federalism going on in our society where we are trying to say, well, that is this party's responsibility or that party's responsibility. Society breaks down.

For example, we have for a long time recognized that education was a society cost. I bear it even though I don't have children and I bear it gladly. And I think it is probably disruptive if you want to talk about philosophy to say, well, this is a cost that those employers who have done something should bear, or that this is a societal cost but for some reason we are not willing to characterize it as such, I think this approach results in bad law and bad analysis.

Chairman STARK. Mr. Pickle.

Mr. PICKLE. You gentlemen who represent NAM and the chamber of commerce, if this bill before us is passed in this form, would this cause employers to get in or out of the health programs? Would it decrease coverage or increase it?

Mr. FAY. We have no studies that could answer that definitively one way or the other. We have comments from our members that suggest for some, it would. And then we get into a debate of economics and economics gets into philosophy.

I would say, in making public policy, it is probably unwise to look at economics. It is a way of putting common sense to the side. For example, even if you prove incremental cost, there is two responses.

So what? When do incremental costs become prohibitive?

Second, if I may go on, average figures are not very revealing in situations where the bill is likely to be troublesome. This bill talks in terms of laid-off employees, although it covers all terminated employees.

But in the laid-off situation, the employer is in trouble, he is suffering an economic downturn.

Chairman STARK. That is what I was addressing with you. It would seem to me this is going to be paid for prospectively and basically through increases.

Therefore, admittedly laying off employees, they are not doing it because they are making a wad of money, but it seems to me that is anticipated by our insurance system.

Mr. FAY. It costs something. It is not anticipated costs now, so you build it in, and you can say, well, it is anticipated cost.

That analysis doesn't mean that there isn't cost that did not previously exist, and the question is who should bear it.

Chairman STARK. I am surprised Labor didn't oppose it on the theory it would make it easier for employers to close plants with a clean conscience.

Mr. Pickle, I am sorry, I didn't mean to interrupt.

Mr. EDWARDS. In costing out the closing of a plant, too, which I think is a concern, employers set aside dollars, be they for severance pay, be they for retraining or the continuation of benefits.

I think if we extended or mandated what was required, we could in effect be taking away some of those retraining costs, be they interviewing skills or things like that, that could ultimately defeat all of our purpose, which is getting that employee back to work.

I would hate to see that happen.

Mr. PICKLE. Well, I asked the question for the purpose of trying to get your position. Most of the individuals who testified today testified in favor of it. As I read your testimony, I had a clear impression you said this would—the cost would be exorbitant, it would be a burden on employers and you run the risk it may drop insurance coverage rather than add to it, and it would be—it might be a detrimental effect instead of a beneficial—I know no studies have been made, so I accept that.

I am trying to ask you, I know you have these concerns, but do you support this bill or not?

Mr. **Klein**. I can answer that and amplify on your earlier question. We do support the tax incentive aspect for the small employers and the demonstration grants. We are not in favor of the extension and have serious reservations about the subsidized risk pools, at least federally mandating them.

To put some——

Mr. **Pickle**. You like the principal but don't like the extension, and you do not approve of the extension or the risk pool.

Mr. **Klein**. What we like are the demonstration grants and the tax deduction for the self-employed person. We note it is already in the Senate tax bill.

Mr. **Edwards**. Our position is identical.

Mr. **Pickle**. I don't take a position one way or another. It seems to me you like the principal, but you would take out the risk pool and the extension. You don't have much left, do you?

Chairman **Stark**. You take what you can get, Jake.

Mr. **Pickle**. I don't know whether you are right or not. I think these questions ought to be explored, and I anticipate we can do it thoroughly and extensively rather than having something that looks good and sounds good.

If you don't like the bill, I hope you would give us some suggestions as to how to change it to meet with your approval.

Mr. **Klein**. Yes, sir.

In that regard, two points. One, as we mentioned earlier, our health care council has set up a task force to look into that, and we are polling our members as to what would be their suggestion as to better ways to do it, and to do it with involvement of the business community.

I want to squarely address the question you asked about—would companies abandon health plans? There are no studies, but we have anecdotal evidence——

Mr. **Pickle**. Although you do not have a study that has been completed, in those nine States where they do have the program in operation, have the premiums remained reasonably level, are they becoming too high, are they bothersome to you?

Mr. **Klein**. We don't know. We refer you to whatever was cited earlier on. I just don't know the answer.

Mr. **Pickle**. You don't know what reaction in these nine States—well, then, how do you form the basis of your opposition if you haven't taken advantage of the history of the nine States where it is operating?

Mr. **Klein**. Because as we have said, we think risk pools may be very well appropriate for dealing with part of the question. It is the matter of mandating them federally, without recognition of the fact that the problem may be different in different States, that we have some concern with.

We just think it needs to be looked at more carefully. We don't necessarily have any opposition to those States that have chosen to adopt it.

Mr. PICKLE. I notice one of you said in your testimony that if the premiums did not cover the losses that automatically the employer would have to pay the extra amount or the State; is that correct?

Is that the way you interpret the bill to work?

Ms. CANNER. I understand the employers will have to pick up the losses, and the losses will be already spread by parts in the pool.

Mr. PICKLE. I am asking for information, but I haven't read this bill. I am just asking, what happens when the costs go up and up? Does the employer pay for it, does the State pay for it?

Chairman STARK. I would imagine you would find the same sort of situation you would find in unemployment insurance. If the unemployment pool runs dry, they raise the unemployment——

Mr. PICKLE. You would assume the State would raise the rate?

Chairman STARK. Yes.

As a matter of fact—in the testimony provided today, these people, in the sense of the lesser of two evils, would suggest things be spread more broadly, like an unemployment tax would be a fairer way to assess the cost. So if the costs rose, as they do now—I think we heard testimony in New Jersey or New York—they are tied to a percentage. As the regular health insurance rises, so will the other part.

Mr. PICKLE. You are saying that the intent is that if the losses exceed the premiums and the matching part, then the State, similar to the unemployment procedure, would raise the rate. So it would be an automatic right the State would have to raise the rates.

Chairman STARK. Did you want to make a comment?

Ms. CANNER. Yes; there is one point I wanted to make. It seems to me, looking at this legislation and what was passed in COBRA, we are moving by steps to try to address this problem. As we mentioned early on, we recognize there is a problem.

One thing we would look at aside from this legislation, we come out and say we oppose particularly the 4 months of mandated coverage, that we take a very careful look at COBRA as it is being implemented, the problems and issues.

We have been collecting some of those questions and have sent them on to the Department of Labor. We look to see how we address those problems and are we closing those gaps and maybe this 4 months of extension can be written in a different way, maybe it is needed, maybe it isn't needed.

I recognize—I think we need a little bit of time to look at this.

Chairman STARK. There are two things you will find in the subcommittee and I think its a bipartisan sense, when we deal with Health and Human Services, a little more time means don't do it ever. And I am not suggesting that that is your intent.

We recognize any legislation that is drafted where you have an adversary role between the legislator and the executive or enforcer can create some problems.

We can either compensate in legislation to give the executive fits or they can say the hell with you, we are going to put so many regulations on top of the legislation that will make it a nightmare.

My hope is that the recent cooperation between the committee and the administration will work those problems out. We understand there needs to be some changes, and we have as much interest in having those procedures as easy for your members to administer. We are not looking for fights.

We would like to extend more benefits and find fair ways to pay for it. That is all we are trying to do.

And I think our philosophy is, and I think I speak for some of my Republican colleagues, that we give the insurance industry, for example, the first crack at it. Private enterprise can go ahead.

But there are some areas that aren't profitable and won't work and somehow that is where we have to pick up the slack or the gap or whatever it is, and that is all we intend to do.

Let your manufacturing colleagues or your chamber of commerce members, if they can work it out. There then is that much less need for us to fill in the gaps. But if they can't, then why shouldn't we do it?

I think we will all save money in the long run. There is no hidden agenda in here. Sometimes the best way to go about it is do it, recognize we won't do it perfectly or we would wait forever, and come back and say let's see how we can improve this and correct the inequities.

I don't know any of us today would have invented the DRG system. It is there. It is better than having two systems, neither of which works.

I see everybody thinks there is a problem out there or everybody agrees to it. It has been there a long time, maybe we can solve it and hopefully without hitting any particular segment, the self-insurers or those still purchasing through a commercial plan and/or those who go it alone, the small businesses who just don't have a program.

Each person has a little different problem. I think we can do it without putting an undue burden or setting some precedent which is going to deny the flexibility a competitive free enterprise ought to have.

Thank you.

Chairman STARK. Mr. Pickle, anything further?

Mr. PICKLE. No.

Chairman STARK. Thank you very much. The hearing is adjourned.

[Whereupon, at 4:15 p.m. the hearing was adjourned.]

[Submissions for the record follow:]

TESTIMONY OF

JOHN P. PAPP, M.D., FACG
PRESIDENT
OF THE
AMERICAN COLLEGE OF GASTROENTEROLOGY

Mr. Chairman and Members of the Subcommittee; the American College of Gastroenterology commends you for your strong commitment and thoughtful approach to alleviating a crisis faced by so many Americans today. That crisis is inaccessibility to health care. We are not talking here about access to quality health care - we are talking about access to any health care. Today, 37 million Americans have no health insurance. In most cases, they have no health insurance either because they cannot afford the high premiums or because they have a pre-existing condition which prevents them from being able to obtain health insurance. Not only does this pose a devastating financial problem for many Americans, but it has been estimated that approximately one million Americans are refused medical treatment because they cannot afford to pay for it.

The American College of Gastroenterology considers the Improved Access to Health Care Initiative a critical step towards assuring the availability of health insurance to all Americans, particularly those most in need of coverage. The legislation's provisions to strengthen employment-based health insurance pools, and develop a mechanism for state funding of hospital charity and unreimbursed care provide a viable solution to this national crisis.

The American College of Gastroenterlogy strongly supports the Improved Access to Health Care Initiative and commends Chairman Stark and the co-sponsors of this legislation for their strong leadership and firm commitment to rectifying the devastating problem of inaccessible health insurance.

American
Dental
Association

ADA

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Suite 1200
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(202) 898-2400

June 24, 1986

The Honorable Fortney Stark
1114 Longworth House Office Building
Washington, D. C. 20515

Dear Mr. Stark:

I am writing to express the views of the American Dental Association on H.R. 4742, the Access to Health Care Act. I ask that these comments be included in the record of your Subcommittee hearings on this legislation.

The American Dental Association supports efforts to assure the availability of private health insurance protection for all. We are particularly supportive of provisions, such as those contained in H.R. 4742 and in the Senate tax reform legislation, to treat self-employed individuals more equally with employees with regard to the purchase of health insurance. We firmly believe that health premium expenses for self-employed individuals at least should be fully tax deductible.

The major theme of your legislation is to improve access to health care through availability of mechanisms to pay for that care. Allowing a tax deduction for self-employed health benefits contributions will go a long way toward assuring that this very large element of our population is able to afford protection for adequate health care. It also is very appropriate to support demonstration projects to assist in the availability of health insurance for the self-employed and other small businesses.

We also are very supportive of provisions requiring continuation of benefits for employees and their families in cases of unemployment. We are pleased that the provisions of your bill would continue all employee health benefits, including dental benefits which now are provided to over 110 million Americans. Although present unemployment rates are relatively low, we think it is extremely important that an individual who has lost his or her job not have to worry about the availability or affordability of health insurance protection during the period when the most important concern should be finding new employment. We support these provisions.

We are not totally clear how the concepts of the statewide insurance pools and requirements for state plans for the uninsured will work and wonder if there may not be some conflict between the two approaches. Certainly the use of statewide insurance pools sponsored by employers and insurers could provide a helpful mechanism for making health insurance available to employed individuals who do not receive these benefits from their employers. Likewise the concept of state reimbursement for uninsured costs incurred by health care providers may have merit. However, we wonder if the availability of state payment for uninsured costs may provide a disincentive for individuals to enroll in statewide insurance pools. Appropriately the state payment program might be limited to covering the costs incurred by low income individuals. However there would seem to already be a mechanism in place, the Medicaid program, to cover these expenses. We believe there should be further development of these concepts.

Finally I would urge the inclusion of a modified version of H.R. 1375, a bill which you introduced, as part of the access to health legislation. The dental profession considers the proposal to be extremely important in furthering access to covered health services, while imposing little or no additional costs on employees. The dental profession has made substantial progress in the courts regarding the applicability of state freedom of choice laws to insured plans. However, the members of the profession and their patients are experiencing more and more frequently problems where self-insured programs, using the presumed preemptive authority of the Employee Retirement Income Security Act, are overriding state access related laws ensuring freedom of choice to health beneficiaries and practitioners.

State laws which assure that employees and their families will have free choice of health care practitioner, assure that all qualified health care practitioners can participate in employer sponsored programs if they agree to the terms of those programs and assure that programs should not be able to discriminate on coverage decisions based on the degree of the practitioner so long as the practitioner is licensed to provide the service involved, have been negated in may states through application of ERISA preemption authority.

We do not believe that the ERISA laws were intended to be applied with regard to health benefit programs and urge that your access to health care legislation include an amendment, such as a modified version of H.R. 1375 or similar language, to clarify that this arbitrary limitation on access to health services is not permitted to continue.

We appreciate this opportunity to comment on H.R. 4742 and look forward to working with you and members of your Subcommittee on this needed legislation to improve access to health care services.

Sincerely

Abraham Kobren

Abraham Kobren, M.S., D.D.S.
President

AK:cs

Coalition for Health Insurance Availability

Statement in Support of the Health Insurance Risk Pooling Provisions of the Improved Access to Health Care Inititive

May 14, 1986

The Coalition for Health Insurance Availability, comprised of 39 national organizations representing individuals with chronic health conditions or disabilities and older Americans, supports the provision of the "Access to Health Care Act" that will provide access to health insurance to individuals and families who are willing but unable to purchase it. This legislation (H.R. 4742 and S. 2402/S. 2403) was introduced on May 1 by Congressmen Stark and Gradison in the House of Representatives and by Senators Kennedy, Durenberger, Heinz and Riegle in the United States Senate.

Many of those unable to obtain insurance coverage are people with developmental disabilities, physical or mental impairments, and chronic health conditions. In many cases these are working people who are willing and able to pay for health insurance but are unable to purchase it because each has a pre-existing condition. In other cases they are older people who, upon leaving their employment, find they cannot purchase individual coverage. At the time they need health insurance most, they are left without it. The inability to obtain adequate insurance has serious consequences not only for these individuals but for their families as well.

The Stark-Kennedy bills would encourage states to establish risk pools to make reasonably priced insurance available to those who cannot purchase it on the open market.

Several models for an effective risk pool already exist. Nine states already have some form of risk pool offering comprehensive major medical insurance to people considered by insurers as "high risks." These states are Connecticut, Florida, Indiana, Minnesota, Montana, Nebraska, North Dakota, Rhode Island, and Wisconsin. Purchasers pay into the pool like any other group health coverage. If the pool experiences losses, those losses are proportionately shared by all the insurers conducting business in the state.

The Stark-Kennedy bill will not require the expenditure of any federal funds. This legislation simply establishes minimum standards based on the experiences of successful state pools. Each pool would be established and regulated in each state similar to other state insurance programs.

Millions of people who, because of health problems, are unable to purchase health insurance in any other fashion, would be afforded coverage. That is why we support the enactment of risk pooling legislation. The Health Insurance Association of America representing the commercial health insurance companies also supports the risk pooling provision contained in the Stark-Kennedy bills.

The denial of health insurance frequently means the denial of health care. It is critical that risk pooling legislation be enacted this year.

COALITION FOR HEALTH INSURANCE AVAILABILITY

ACLD, Inc. An Association for Children and Adults with Learning Disabilities
Alliance for the Neurologically Impaired
American Association of Retired Persons
American College of Gastroenterology
American Diabetes Association
American Foundation for the Blind
American Liver Foundation
American Medical Student Association
Amyotrophic Lateral Sclerosis Association
Arthritis Foundation
Association for Retarded Citizens
Cooley's Anemia Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation of America
Handicapped Organized Women, Inc.
Health Insurance Association of America
Huntington's Disease Foundation of America
Immune Deficiency Foundation
Lupus Foundation of America
National Association of Children's Hospitals and Related Institutions, Inc.
National Association of Developmental Disabilities Councils
National Coalition for Rare Disorders
National Consumers League
National Easter Seal Society
National Head Injury Foundation
National Foundation for Illeitis and Colitis
National Huntington's Disease Association
National Mental Health Association
National Multiple Sclerosis Society
National Rehabilitation Association
National Society for Children and Adults with Autism
National Sudden Infant Death Syndrome Foundation
National Women's Health Network
Sickle Cell Support Association
Sick People Need Insurance (SPINS)
Sick Kids Need Involved People (SKIP)
Spina Bifida Association of America
Tourette Syndrome Association, Inc.
United Cerebral Palsy Associations, Inc.

For Further Information:

Myrl Weinberg (703-549-1500) American Diabetes Association	OR	Richard Nugent (301-459-3700) Epilepsy Foundation of America

Testimony of
The ERISA Industry Committee

for the
Subcommittee on Health
Committee on Ways and Means
U. S. House of Representatives

Hearing on H.R. 4742
Health Care Improved Access Act of 1986

Monday, June 9, 1986

The ERISA Industry Committee appreciates the opportunity to present its views on H.R. 4742, The Health Care Improved Access Act of 1986.

The ERISA Industry Committee (ERIC) represents the concerns of major U.S. employers on public policy matters affecting private sector retirement and employee benefit plans. ERIC's over 100 members provide important retirement, health, and other life security protections for over an estimated 10 million active and retired workers in every state of the nation.

ERIC companies have long played a leadership role in providing affordable and cost effective health coverage to their employees and their dependents.

We are deeply concerned about and strongly object to Sections 2, 3 and 4 of H.R. 4742. These sections would:

(1) decrease rather than increase employer-sponsored health coverage;

(2) further inflate the cost of health care by providing a disincentive for fiscal restraint under the new health coverage provided by the bill;

(3) unfairly impose the costs of subsidized health insurance pools on only those private sector employers already shouldering substantial health care burdens; and

(4) impose on these same employers a disproportionate share of health care responsibilities.

We do not believe that these are results that the bill sponsors or the Committee would find acceptable, and we offer the following comments in an effort to point out the problems that would be created by H.R. 4742.

STATEWIDE INSURANCE POOLS

Section 2 of H.R. 4742 requires all states to establish state pools to finance health coverage for all residents of the state who are not eligible for Medicare. The coverage provided must limit out of pocket expenses to $1,500, include a lifetime benefit limit of not less than $500,000, cover pre-existing conditions after six months, and charge a premium of no more than 150 percent of the average premium for individual standard risks in the state.

If the premiums charged to individuals fail to finance all of the required benefits, the employers that already provide coverage for their own employees would, in addition, have to pay for the additional costs of the pool. Any employer that provided coverage for its employees but did not participate in the pool (even where the state failed to create such a pool) would be required to pay a tax equal to ten percent of the health expenses that it incurred on behalf of its employees.

By contrast, a competitor that provided no health coverage for its employees would not have to participate in the pool and would not be subject to the ten percent penalty tax.

No government entity would participate in the costs of the subsidized pool or be subject to the tax.

The money raised by the penalty tax would be part of the general treasury; it would not be reserved to provide health care benefits.

The provisions of Section 2 provide a combination of incentives for increased cost and disincentives for expansion of employer-provided health coverage that ERIC finds disturbing, unfair and counterproductive.

Under the terms of the bill an employer would pay a penalty tax of 10% of the health benefits provided to its employees if a state's legislature fails to pass or chooses not to pass risk pool legislation meeting the requirements of the bill. There is no justification for taxing an employer on the basis of what a state legislature chooses to do or not to do.

Moreover, state legislatures that do establish pools will be under political pressure to keep the premiums charged to individuals low. Our preliminary analysis, based on costs of a major company plan with general health benefits similar to the requirements stipulated in the bill indicate premiums for coverage required in the bill would amount to approximately $60 per month for individuals and $160 per month for families. Given the low average wage of individuals who do not have employer-provided health coverage, premiums of this magnitude would be too high for widespread use. As a result, only those individuals who are most likely to file claims will choose to join the pool. Our calculations were based on a standard risk population. However, H.R. 4742 requires coverage of pre-existing conditions after six months. Both the costs of the participation in the pool and the coverage pre-existing conditions will cause adverse selection. This adverse selection will increase costs even further. The premium costs almost certainly will have to be subsidized heavily by the risk pool.

Moreover, there appears to be no limit on the benefits that a state could require to be covered under a state risk pool. 600 state mandated benefit laws are now on the books. A legislature will be under political pressure to extend those requirements to a state risk pool. Benefits mandated by current state laws include coverage for podiatry, chiropractors, drug abuse, alcoholism, social workers, acupuncture, sterilization, liver transplants, in vitrofertilization, pastoral counseling, chinese medicine, "all healing arts practitioners", and a host of other benefits. However meritorious, these benefits are not "basic health care."

Although little data currently exists on the impact of existing risk pools, the movement of large employers toward self-insured plans, which currently are not subject to state pooling arrangements, the reduction in the coverage provided by smaller employers, and the insistence by sponsors of insured plans that other entities should shoulder some of the cost of these pools all indicate that risk pool subsidies are proving expensive. Available data indicate that the cost of the pool subsidies is increasing faster than the general increase in health care costs.

The bill provides no mechanism for fiscal restraint on health care costs or on the subsidy of those costs. State entities will set the coverage and subsidized premium levels. Employers already providing coverage to their employees will pick up the cost. Even the normal restraints that exist when a government body must levy taxes in order to pay for services do not exist here. This bill extends the "deep pockets" theory of liability to health insurance.

The exemption for small employers would exempt from the costs of the risk pool subsidy highly profitable businesses, including professional corporations, while imposing added cost burdens on larger employers that may or may not be profitable at any given time.

The exemption of government entities from the costs of the risk pool subsidy would dramatically increase costs for other employers in states with high concentrations of federal or other government installations, reducing the ability of such states to attract profitable private sector employers.

Since it is based on health expenses paid during the year, the ten percent penalty tax would reward employers that provide little or no health benefits and would penalize employers that provide more adequate benefits.

For all of these reasons, ERIC opposes the risk pool provisions of H.R. 4742. The net impact of this portion of the bill as written will be to provide

additional health coverage for a minimal number of individuals at a high cost while reducing general coverage under employer-sponsored health plans, that now protect over 150 million Americans.

STATE PLANS FOR UNCOMPENSATED CARE

Section 3 of H.R 4742 requires that each state establish a comprehensive program to pay for uncompensated care throughout the state if hospitals in the state are to continue their Medicare eligibility.

While pursuing the bill's goal of ensuring that all individuals have access to health care, these provisions would also have adverse effects:

(1) By providing compensation only for hospital care, the uncompensated care provision would subvert the current effort to provide cost effective care by minimizing to providing alternatives to hospital care.

(2) Since medical needs would be handled through a state system, the provisions provide further incentives for some employers not to assume the costs of providing care for their workers.

ERIC recognizes that uncompensated care is an important and increasing national problem. Solutions in this area, however, should both recognize the variety of means by which health care can be provided both inside and outside hospitals and should not be so broad in scope as to encourage employers to avoid providing coverage for their own employees.

PROVISION OF EMPLOYER PAID INSURANCE FOR FORMER EMPLOYEES AND OPEN ENROLLMENT FOR SPOUSES

Section 4 of the bill requires private sector employers that provide health coverage for their employees to extend that coverage under the same costs and conditions for a period of time for any employee who leaves.

Despite the use of the term "laid off employees" in the section heading, this provision would include all former employees -- employees who voluntarily quit, who retire, or whose employment is terminated for cause, as well as employees who are laid off in a workforce reduction. Only employees terminated for "gross misconduct" (an extremely limited term) would be excludable.

No minimum service is required for eligibility for the extended coverage. The bill requires employers to pay for continued health coverage for four months or for the number of months the worker was provided coverage under the company's group plan, whichever is less. As a result, employers -- particularly employers with high turnover in the first months of employment -- would be strongly discouraged from providing any health coverage at all to employees until they have been with the company for some time. Thus, coverage gained at the back door could be more than lost at the front door.

The range of benefits for which coverage must be maintained appears to be extremely broad. Under such broad definitions, a former employee may have strong incentives to seek elective treatments under dental or vision care programs or other similar benefits "before time runs out." Such adverse selection would increase costs of these programs and reduce the ability of employers to offer them on an ongoing basis to active employees while not providing any significant additional protection against medical emergencies for former employees.

RECOMMENDATIONS

1. Precipitous action on a bill vaguely drafted and containing major disincentives to the continued general coverage of workers and dependents would be a mistake. The Committee should hold additional hearings and explore other approaches to correcting the problems addressed by the bill instead of deciding on the course of action mandated in H.R. 4742.

2. In no instance should the cost of providing coverage for non-employees be imposed solely on private sector employers that are already providing coverage for their employees while other employers and government

entities reap the benefits without assuming their fair share of the costs.

3. Similarly, there is no reason to exempt small employers from this societal cost. Many small employers, including professional corporations, may be in a stronger financial condition than the larger employers targeted by the bill.

4. If fiscal responsibility is to be maintained, those paying for the care must have a direct voice in determining the extent of benefits and coverage provided.

5. Non-hospital care should be used to provide affordable health care.

6. Minimum service requirements should be imposed before employees are eligible for continued coverage in order to avoid creating an incentive for employers to delay coverage of newly hired workers and to prevent some workers from taking unfair advantage of the system.

7. All revenue gained from any programs adopted should be specifically dedicated to the health care of those the bill seeks to protect.

8. Employees whose employment is terminated voluntarily or for cause should be excluded from continued coverage (cf. standards used for unemployment compensation).

9. If the federal government mandates additional coverage, the scope of ERISA preemption should be expanded to pre-empt existing state laws that mandate coverage or benefits.

10. The tax imposed on employers for actions taken or not taken by state legislatures should be removed from the bill.

11. Finally, the scope of benefits required to be provided under risk pool and post employment programs should be narrowed.

STATEMENT OF

CONGRESSWOMAN BARBARA B. KENNELLY

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

JUNE 9, 1986

I want to thank Chairman Stark for allowing me to testify today on H.R. 4742, the Health Care Improved Access Act of 1986. I believe he and Mr. Gradison should be commended for raising the issue of access to health care in this comprehensive fashion. With 37 million Americans still without health insurance coverage, this hearing could not be more timely or more important in stimulating a discussion of methods by which to fill this health care gap.

My testimony will be limited to Section 2 of H.R. 4742, which deals with the creation of "risk pools" in the states to guarantee the availability of health insurance to all residents. This section of H.R. 4742 is similar to H.R. 1770, legislation that I introduced last year, which was cosponsored by Messrs. Stark, Gradison and 30 of our colleagues. Building on H.R. 1770, several changes have been made in the bill to ensure the states provide better coverage at lower cost to participants in the risk pools -- changes I wholeheartedly endorse.

I would like to point out that risk pools are a tested product. They have operated successfully in the states since 1975 when my own state of Connecticut pioneered the concept. We formed the Connecticut Health Reinsurance Association to offer comprehensive health insurance to all our citizens, regardless of their health status. Eight other states have similar programs now, covering 20,000 Americans. We can do better than this, however. Now is the time to take this program nationwide.

Let me give you an example of who would be helped by risk pools.

When Maria was 39, she lost her job, and, with it, her group health coverage. Shortly later, she developed lupus, a disease that affects the immune system and can damage vital organs. Her husband changed jobs soon after, and his new health policy would not cover Maria's pre-existing disease. Maria's medical bills mounted to $28,000 before she was able to get a job offering large-group coverage.

Stories like this are becoming increasingly common. Medical science can save the lives of more people than ever before, but it can't save their health insurance. Of the 37 million Americans who have no health insurance at all, many simply fall through the cracks: They are too young for Medicare, too well-off for Medicaid, and too sick for private health insurance. For them, illness is both a personal tragedy and a financial catastrophe. They have become uninsurable.

The uninsurables include the families of children with special health needs, such as spina bifida and muscular dystrophy. The average hospital stay for a cystic fibrosis victim, for example, runs 14 days and costs between $8,000 and $10,000. Few families can afford such staggering expenses, yet only 40 percent of the patients seen in cystic fibrosis care centers are covered by private health insurance.

The uninsurables also include adults with illnesses like heart disease, high blood pressure, or cancer. Some can obtain large-group coverage through their employers. But those who work for small employers without group health plans and those who leave the workforce by choice or necessity may find it impossible to get health insurance.

Fortunately, risk pools offer a simple, proven solution to this problem. Just as state-wide pools now offer automobile insurance to high-risk drivers, so health insurance risk pools can make health insurance available to all who need it -- and at no cost to the taxpayer.

The Health Insurance Availability Act, H.R. 1770, and H.R. 4742 would provide a powerful incentive for establishing such risk pools by presenting every company offering insurance in a state, including employers who are self-insuring, with a choice: participate in a qualified risk pool or pay a 10 percent federal excise tax on health care costs. In reality, of course, this excise tax would never be collected. Joining a a risk pool would cost far less than paying the tax.

The risk pool would offer health insurance coverage equivalent to that provided by large employer groups. Deductibles would be limited, as would pre-existing condition restrictions and out-of-pocket expenses.

The premiums for insurance purchased through the pool would be high. After all, the pool is composed exclusively of those who cannot purchase insurance elsewhere. Even with high premiums, losses are inevitable. But the losses would be shared on a pro rata basis; no one insurer would suffer a competitive disadvantage. Most important, anyone who was able to pay for health insurance would be able to get it.

This legislation would not fill every crack in the health care system. It does not, for example, directly address the high cost of health care. It does partially address the increasingly serious problem of uncompensated care.

The bill does not solve the health care problems of the poor. But it will prevent some middle class Americans from becoming poor.

The bill does not guarantee that everyone will have health insurance. But it will ensure that it is available to all. That is a small but important step, and one we should take now.

In closing, I would like to thank you, Mr. Chairman, and Mr. Gradison for your interest and support on this issue. I think we need this legislation, and will be more than happy to continue to work with you on it.

NFIB® National Federation of Independent Business
The Guardian of Small Business®

STATEMENT OF
JOHN J. MOTLEY, III
DIRECTOR OF FEDERAL LEGISLATION
NATIONAL FEDERATION OF INDEPENDENT BUSINESS

on H.R. 4742
for the hearing record of the

SUBCOMMITTEE ON HEALTH
HOUSE WAYS and MEANS COMMITTEE

June 1986

On behalf of the 500,000 small and independent business owners who belong to NFIB, I appreciate the opportunity to participate in this committee's investigation into the problems of access to private health insurance and the possible impacts of H.R. 4742. NFIB is a voluntary membership organization with over 500,000 small business owner members. Our membership comes from all of the industrial and commercial categories and reflects the national small business community in its distribution among industries. That is, we have about the same percentage of members in the construction industry, the manufacturing industry, wholesale, retail, etc., as exists in the national business profile.

I am not an expert in the health care industry or in the insurance industry, therefore my remarks are primarily directed to a description of the attitudes and operational characteristics of the small business community in America. The primary basis for my remarks come from two national surveys we have conducted in this general area. The first was done in 1978 and is entitled *National Health Insurance Report on Small Business*. The second, conducted in late 1985, is entitled *Small Business Employee Benefits*. In addition to these survey results we also periodically poll our entire membership on their attitudes toward public policy issues. First, I will summarize some of the results of our survey material, then I will briefly discuss their policy implications from small business' point of view.

The number of small business owners providing employee health insurance has been rising. Sixty five percent of firms offer health insurance for at least some full time employees, an increase of eight percentage points from a similar finding in 1978. Forty two percent of small firms provided health insurance to all full-time employees.

The vast majority of firms in all size categories offer plans that include hospitalization/surgical and major medical. In the aggregate, nearly two-thirds of these employers pay the entire premium cost, with smaller firms more likely to pay 100% of the premium than larger firms. Most responsible for the increased coverage are firms in financial service, professional service, retail, and smaller firms in general.

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Well over 80% of health insurance plans offered in small firms carried an option for dependent coverage. However, few part time employees were provided any health benefits.

The mean health insurance premium paid by small employers was over $1,766.00, more than double the monthly premiums paid in 1978.

Small business owners purchased private health insurance from a great variety of carriers. Self insurance (4%) and HMO (3%) remained an oddity among small firms.

While the firm was the group sponsor more often than not, trade/business associations have been increasingly taking that role. We believe, the trend to greater association sponsorship is tied directly to increasing employee health coverage in small firms.

Small business owners and/or a designated employee spent comparatively little time searching for health insurance alternatives, health care cost control options, etc. Outside advisors, particularly insurance agents, often substituted for owner/employee search.

Employee health insurance was not provided by about 1/3 of small employers. No single reason dominated their decisions. The most frequently cited reasons were: employees covered under a spouse or parent policy (secondary wage earners), premiums were too high, employee turnover was too great, the firms profitability was insufficient, or the firm couldn't qualify for a group policy.

While small employers will increasingly provide health insurance for their employees, it is unclear just how dramatic this increase will be. The composition of the labor force and differences in small business profitability will limit growth in the proportion of small business owners instituting employee health insurance plans. Coverage will continue to increase as health care cost decline, labor markets accept it as a condition of employment, and as associations make group plans increasingly accessible to the smallest firms.

Blending our survey results with our policy polls, small business overwhelmingly opposes any government-mandated health insurance program, or, indeed, any government mandated minimal insurance coverage. The 1/3 of small firms which are not now offering any health insurance to their employees are not doing so primarily because of labor market composition problems or profitability problems--neither the small business nor the government can change these realities. If, however, policy makers decide to mandate certain requirements in this area, these market realities need to be recognized. Otherwise in trying to get coverage for certain target groups, new gaps could be created by discouraging voluntary employer sponsorship of health plans. The potential for this problem could be minimized:

- o by not requiring a period of employer paid insurance benefits beyond job termination;
- o by exempting seasonal and short-term employees from coverage;
- o by recognizing the large proportion of secondary wage earners in small businesses and eliminating the potential for their double coverage;
- o by provisions to allow for sharing the cost between employers and employees, unless otherwise privately agreed upon;
- o by keeping any such program simple and in the private sector to the greatest extent possible;
- o and by not even considering increasing payroll taxes to pay for any such programs, premium payments would be most appropriate.

The other major reasons for small business non-coverage of employees are that premiums are too high and that their firms do not qualify for group policies. These problems may be more amenable to public policy correction, but I will leave that judgment to others for the moment. The market does seem to be moving to correct even these barriers to coverage.

What all this means for NFIB's position on H.R. 4742 is as follows:

- we oppose employer paid health insurance beyond job termination as too expensive and an administration nightmare (section 4);
- we support the health insurance deduction for self employed individuals (section 5);
- we support the call for studies and demonstration grants on ways to reduce the costs of health insurance for small businesses (section 6);
- we have reservations about the statewide pools and the open enrollment period for spouses of unemployed workers (sections 2 and 4);
- and we are neutral on requiring state programs for the uninsured and underinsured (section 3).

0251T

NFHO

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Buffalo House Staff Association
California Association of Interns and Residents
Cambridge Hospital House Officers Association
Committee of Interns and Residents (New York/New Jersey)
Cook County House Staff Association (Chicago)
Joint Council of Interns and Residents (Los Angeles)
San Francisco Interns and Residents Association

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STATEMENT

OF

THE NATIONAL FEDERATION

OF

HOUSESTAFF ORGANIZATIONS

ON

HR 4742

THE HEALTH CARE IMPROVED ACCESS ACT

The needs of the growing number of medically indigent in this country have been cast aside in the drive for cost containment of healthcare. As profit replaces service as the motivating force of the industry, the role of government to intervene becomes increasingly necessary.

The doctors of the National Federation of Housestaff Organizations work on the front lines of healthcare delivery to the medically indigent. We are the residents who staff the emergency rooms, the clinics, the wards, and the intensive care units of many of the nation's hospitals in medically underserved areas. In particular, we work in public hospitals. These institutions of 'last resort' provide the only medical care to the anywhere from 28 to 50 million Americans without insurance or the means to pay. Everyday, we see the tragedy of these statistics in human flesh and blood.

Thus, we applaud Representatives Stark and Gradison for the introduction of the Health Care Improved Access Act of 1986. As the influence of for-profit hospitals grows in the private sector, the historical role of the voluntary hospitals providing 'charity care' diminishes. And it is public sector hospitals that increasingly carry the burden...financial and medical.

Our friends in the AFL-CIO have testified eloquently on the particulars of your legislation. We want to add emphasis to four of their points on the provision for state systems to fund hospital care for the medically indigent.

1. First and foremost, we hope that the growing awareness of this problem reflected in the introduction of this bill leads towards the introduction of a comprehensive national health program. HR 4742 only provides band-aids for a gaping wound in American society. A national health program would not only provide insurance coverage for all Americans, but, as our colleagues have shown in Canada, it would develop a medical education system based on rational health needs and thus address the growing chaos in the medical profession.

2. Public hospitals should be targeted in your legislation. Although they receive monies from municipal budgets, this by no means covers the disproportionate share of 'bad debt and charity care' they provide.

3. The legislation should stipulate that a state plan be based on patient care (as in New Jersey) rather than hospital reimbursement (as in New York). While both plans attempt to address the same problem, the former addresses it from the financial and medical needs of the patient whereas the latter does from the financial needs of the hospital.

4. We encourage the Subcommittee to carefully consider the AFL-CIO's upcoming model legislation on this issue. From what we have learned working for better patient care on a municipal and state level, the problem of care of the indigent can only be alleviated with direct input from hospital care providers and patient consumers. The AFL-CIO's proposals mandate that input.

In closing, we are encouraged by the Subcommittee's role in providing leadership in this area. As you did last year in legislating the disproportionate share adjustment and refusing to make massive cuts in graduate medical education, once again you are looking after the health care needs of all Americans.

Submitted by

Jonathan House, M.D.
Administrator

STATEMENT OF
SELF INSURANCE INSTITUTE OF AMERICA, INC.
ON
"THE IMPROVED ACCESS TO HEALTH CARE INITIATIVE"
(H.R. 4742)

June 13, 1986

This statement is submitted on behalf of the Self Insurance Institute of America, Inc. ("SIIA"), a national association of over 600 members including employers, third-party administrators, reinsurance companies and other interested parties dedicated to the improvement of the self-insurance industry.

SIIA appreciates the opportunity to express its views on H.R. 4742, "The Improved Access to Health Care Initiative", sponsored by Rep. Stark, which would, among other things, require that employer sponsored group health plans provide health insurance benefits for four months for employees who are laid off.

In brief, SIIA supports the present system of voluntary, employer sponsored health plans which provide benefits to millions of employees. These plans are tailored to meet the varying needs of employers and employees in accordance with the unique requirements of the employer-employee relationship. SIIA opposes federal controls which would mandate special coverages because they would increase already spiralling private sector health costs and limit flexibility in plan design. Such action will impact adversely on the private voluntary system and will create less rather than greater coverage. Indeed such legislation would be particularly burdensome for smaller employers who may have to lower wages or eliminate group coverage altogether.

Federal Mandates Will Reduce Coverage

For over 50 years employers have taken the initiative on a voluntary basis to provide employer sponsored, and in many cases, employer paid health benefits to their employees. Recently, the President signed into law legislation which mandated that employer sponsored group health plans, whether insured or self-insured, must allow previously covered spouses and dependents of former employees to elect to continue health coverage. On the heels of this new law, Congress is now considering yet another Federal law, H.R. 4742, which would intrude once again into the private health care system by mandating that additional benefits be provided under private plans. This law requires, among other things, four months of employer paid health benefits for laid off workers. This latest mandate will make it even less attractive for employers, particularly small employers, to continue to provide employer sponsored health benefit programs. In short, as the Federal government continues to mandate the inclusion of health care benefits, we are concerned there will be a deterioration of this voluntary system and employers will elect to discontinue providing employer sponsored (paid) health care coverage. Thus, we submit that H.R. 4742 is not in the best interest of employees, dependents of employees, employers, providers of health care, and the general population.

Private Voluntary Health Care System Works Effectively

The vast majority of our population is in fact covered by some form of health care, whether provided through private group funding arrangements or through the Government. Private sector plans are designed to meet the specific needs and financial resources of employers and employees. Employers now spend an estimated $100 billion each year on health care for their employees. As employer sponsored health care plans have multiplied, basic medical coverages have expanded, and new programs have been added to cover medical expenses beyond the traditional exposures. For example, dental protection as well as other forms of health care protection such as vision care, long term and short term disability are now provided under many employer sponsored health care programs. Moreover, ERISA gave employers an opportunity to provide uniform benefit plans without state government interference when they elect to self-fund the benefits rather than use the services of a commercial insurer. ERISA's broad Federal preemption provisions, which preclude state regulation of welfare benefits plans, implicitly reflects Congress' rejection of minimum standards for such plans, including coverage. This private system is working well and should not be burdened with costly new requirements which would inhibit its continued growth.

H.R. 4742 will erode the concept of voluntary employer sponsored programs. Although the concern of government to expand the availability of health insurance to those who are not presently covered is understandable, we do not believe the answer to this problem lies in mandating the inclusion of such coverage in private plans. In effect, H.R. 4742 seeks to establish a form of national health care, by shifting costs to employers rather than to the public.

Reasons For Rejecting New Federal Mandate

H.R. 4742 should be rejected for the following reasons:

1. It places new burdens on the free enterprise system which will result in increased costs to employers. The cost to provide and fund benefits for the uninsured will be passed on to the employer in the form of: (a) increased administrative cost; (b) poor plan experience causing increased cost to all participants; and (c) adverse selection against the plans. It is interesting to note however, that government is exempt from the provisions of H.R. 4742, undoubtedly reflecting the concern of the authors over the cost implications of their legislation.

2. H.R. 4742 would favor interest groups especially those who represent the provider sector of the health care industry. For the past several years, health care costs have continued to rise and treatment of conditions in many situations may have gone far beyond what is required. Providers have long capitalized on funding their services through group health care arrangements. The medicare program is living proof of what a blank check can do to any provider. This will surely exacerbate the problem of rising costs.

3. H.R. 4742 mandates that employers must continue their group health plan for employees who terminate regardless of the reason for termination. Employer sponsored plans are designed to cover the active work force, not those who elect to leave the company or are laid off. In fact most group plans already contain provisions for such occurances and in many cases provide the right to convert to individual plans. However, such rights are not granted regardless of the reasons for termination. To mandate that employers must continue coverage for employees who terminate and, at the cost of the employer, will undermine the employer-employee relationship and will create a further incentive for many employers to drop their employer sponsored benefit plans. Should this occur, an even greater "uninsured" problem will be created.

4. The provision for special "open enrollments" would have a devastating effect on group plans. H.R. 4742 provides the opportunity for covered persons to "select" against the group plan which will result in higher benefits, resulting in adverse experience requiring substantial rate adjustment to the employer sponsored plan. This is unfair cost shifting.

5. H.R. 4742 also requires all states to establish "pools" to cover all people who do not have health insurance, even if they elected not to purchase coverage on their own. Yet, many states already have in place some form of social aid and state residents as well as business are already helping to fund these state programs. H.R. 4742 will only serve to complicate matters and make "health care abuse" an even more attractive activity than it already is.

On the positive side, H.R. 4742 would create a new incentive for small business to provide benefits to all employees as well as the owners of sole proprietorships, partnerships and sub-chapter corporations. Under this provision, employers will be able to deduct their personal premium provided they extend the offer to include their employees under the plan. This provision we can support.

In conclusion, H.R. 4742 does not solve the problem of providing coverage to uninsureds. It would only place further burdens on the private system and will encourage greater abuses in the health care provider sector. Inevitably reduction in the protection aforded by private health plans will place new burdens on already over utilized government programs. We urge you to reject H.R. 4742 and to continue present broad tax incentives for American business to continue to provide effective employer sponsored health care plans without mandating the content and scope of these plans.

SERVICE EMPLOYEES
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JOHN J. SWEENEY
INTERNATIONAL PRESIDENT

RICHARD W. CORDTZ
INTERNATIONAL SECRETARY-TREASURER

July 9, 1986

TO: House Ways and Means Committee Members
FR: Service Employee International Union
RE: Statement on "The Health Care Improved Access Act of 1986", HR4742

Attached please find SEIU's statement on the Health Care Improved Access Act of 1986, HR4742, that is being considered by the House Ways and Means Subcommittee on Health.

SEIU strongly supports HR4742 because it:

-- extends employer-paid health coverage to laid-off workers and their dependents for up to 4 months;
-- utilizes state insurance risk pools to extend health care coverage to those who can not get it; and
-- requires states to either establish plans to fund the uncompensated care of hospitals or to develop a system to provide health insurance to all uninsured residents;

SEIU urges you to modify some elements of the plan to:

-- require that all employers share the costs of creating these state risk pools;
-- include federal standards to insure that the needy are not excluded due to stringent eligibility standards or co-payments;
-- design a mechanism to ensure that public hospitals serving the poor and elderly get their fair share of uncompensated care funds; and
-- design a funding mechanism for uncompensated care that includes the participation of health care providers, health insurers and the federal and state governments.

SEIU also urges Congress to build on HR4742 by considering mandatory health coverage for workers, who are 75% of the uninsured, and expanding the Federal role in supporting public health care.

If you have any further questions regarding SEIU's position on HR4742, please contact Geri Palast, Director of Legislation at 898-3360 or Cathy Schoen, Director of Research at 898-3350.

STATEMENT OF
THE SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC
ON
THE HEALTH CARE IMPROVED ACCESS ACT OF 1986 (H.R. 4742)

THE SERVICE EMPLOYEES INTERNATIONAL UNION REPRESENTS 850,000 WORKERS. AS LOW-WAGE WORKERS IN THE SERVICE SECTOR, SEIU MEMBERS FIGHT EVERY DAY FOR DECENT HEALTH BENEFITS FOR THEIR FAMILIES. AS HEALTH CARE WORKERS--OVER 275,000 OF OUR MEMBERS--WE KNOW FIRST-HAND THE OBSTACLES TO HEALTH CARE IN AMERICA.

UNTIL RECENTLY, OUR SOCIETY HAD BEEN MAKING STEADY PROGRESS TOWARD THE GOAL OF PROVIDING DECENT, AFFORDABLE AND ACCESSIBLE HEALTH CARE FOR ALL AMERICANS. INDEED BY THE MID 70'S IT LOOKED AS IF THE GOAL OF COMPREHENSIVE HEALTH COVERAGE, ALBEIT ORGANIZED PRIMARILY THROUGH PRIVATE INSURANCE PLANS AND NOT THE NATIONAL HEALTH PROGRAM LONG ADVOCATED BY LABOR, WAS WITHIN OUR GRASP. AND CONGRESS SUPPLEMENTED THIS PRIVATE HEALTH INSURANCE NETWORK WITH TWO FEDERAL PROGRAMS--MEDICARE AND MEDICAID--DESIGNED TO COVER MEDICAL CARE FOR THE ELDERLY AND POOR.

BUT FOR THE PAST FEW YEARS, WE HAVE BEEN MOVING STEADILY BACKWARDS. YEARS OF PROGRESS TOWARDS COMPREHENSIVE, EMPLOYER-PROVIDED HEALTH INSURANCE FOR WORKERS AND THEIR FAMILIES HAVE BEEN STOPPED COLD AND A STEADY EROSION IN THE NATION'S PRINCIPLE SOURCE OF COVERAGE IS UNDER WAY. CUTS IN HEALTH CARE BENEFITS, TIGHTENED ELIGIBILITY RULES AND MILLIONS OF FAMILIES LOSING HEALTH INSURANCE ALONG WITH THEIR JOBS ARE THE MOST VISIBLE THREATS TO A HUMANE AND RATIONAL HEALTH SYSTEM.

TODAY, MORE THAN 37 MILLION AMERICANS HAVE NO PRIVATE OR PUBLIC HEALTH INSURANCE, UP BY 50% IN JUST FIVE SHORT YEARS. PERHAPS ANOTHER 50 MILLION (GOVERNMENT RESEARCH CORPORATION) HAVE WOEFULLY INADEQUATE HEALTH BENEFITS. THAT'S ONE IN FOUR AMERICANS.

THE GROWING NUMBER OF UNINSURED AND UNDERINSURED FACE STRONG OBSTACLES TO OBTAINING ACCESS TO OUR HEALTH CARE SYSTEM. WHILE MANY FIND MEDICAL CARE BY ONE MEANS OR ANOTHER, THIS CARE IS UNEVEN OR NON-EXISTENT FOR MANY.

OUR PUBLIC AND VOLUNTARY HOSPITALS ARE FILLED TO OVERFLOWING WITH PATIENTS TRANSFERRED FROM OTHER FACILITIES. OUR NURSING HOMES TREAT ALL BUT THE WELL-TO-DO WITH ONLY SKELETAL STAFF OR DENY THEM ADMISSION ALTOGETHER. ACCORDING TO A RECENT STUDY BY THE ROBERT WOOD JOHNSON FOUNDATION, ONE MILLION PEOPLE IN 1983 WERE REFUSED MEDICAL TREATMENT. ANOTHER FOUR MILLION FAMILIES REPORTED THAT THEY OR SOMEONE IN THEIR FAMILIES DID NOT SEEK OUT NEEDED MEDICAL CARE.

ACCESS TO CARE HAS NOW BECOME A NATIONAL ISSUE; IT IS A NATIONAL SHAME. IN THIS NATION OF MEDICAL EXCELLENCE, WE FIND THAT WE ARE NOT PROVIDING FOR THE PUBLIC HEALTH. AT THIS CRITICAL JUNCTURE IN DESIGNING OUR NATION'S HEALTH CARE SYSTEM FOR THE NEXT CENTURY, WE MUST DECIDE WHETHER TO TAKE THE NECESSARY STEPS TO REVERSE THIS TREND. THE ALTERNATIVE IS UNACCEPTABLE--A TWO-TIERED HEALTH SYSTEM DIVIDED INTO "HAVES" AND "HAVE-NOTS".

WE STRONGLY SUPPORT H.R. 4742, THE "HEALTH CARE IMPROVED ACCESS ACT" OF 1986, AS AN INITIAL STEP TOWARD SOLVING THE LARGE AND GROWING PROBLEM OF AMERICANS WITHOUT HEALTH COVERAGE. THE BILL TAKES A TWO-PRONGED APPROACH--TO INCREASE THE INSURED POPULATION AND TO

FINANCE HOSPITAL CARE FOR THOSE WHO REMAIN UNINSURED. SEIU COMMENDS THE CHAIRMAN AND RANKING MEMBER OF THIS SUBCOMMITTEE, REPRESENTATIVES STARK AND GRADISON FOR INTRODUCING THIS IMPORTANT LEGISLATION. WE URGE THE SUBCOMMITTEE TO GIVE H.R. 4742 PROMPT, FAVORABLE CONSIDERATION.

THIS ACCESS TO CARE BILL COMES ON THE HEELS OF THE 1986 CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT WHICH TOOK STEPS TO CONTINUE COVERAGE FOR LAID-OFF WORKERS FOR UP TO 18 MONTHS AND FOR 3 YEARS, FOR DIVORCED SPOUSES AND FAMILIES OF WORKERS WHO DIE. (THE INDIVIDUAL PAYS THE BILL.)

OVER THE LONG HAUL, WE BELIEVE THAT THERE MUST BE AN EXPANDED FEDERAL ROLE--BOTH IN SUPPORTING MEDICAID AND THROUGH REQUIRING MANDATORY PRIVATE INSURANCE FOR ALL WORKERS. AS A FURTHER EFFORT, WE SHOULD FOCUS ON FEDERAL LEGISLATION WHICH IS NEEDED TO TEAR DOWN THE BARRIERS TO CARE BEING ERECTED BY AN INCREASINGLY COMPETITIVE HEALTH CARE MARKET BASED ON ABILITY TO PAY.

THE REMAINING TESTIMONY WILL FOCUS ON (1) WHY FEDERAL LEGISLATION IS NEEDED; (2) THE PROVISIONS OF H.R. 4742; AND (3) ADDITIONAL SOLUTIONS NEEDED DOWN THE ROAD.

THE CAUSES OF GROWING MEDICAL INDIGENCE

THE LARGE AND GROWING UNINSURED POPULATION STEMS IN PART FROM MEDICAID BUDGET CUTS WHICH FORCED STATES TO TIGHTEN THEIR ELIGIBILITY STANDARDS. AS A RESULT, THE PROPORTION OF POOR AMERICANS INSURED BY MEDICAID DROPPED SHARPLY FROM 63% IN 1975 TO 43% IN 1983. THIS DECLINE CAME IN THE FACE OF A 27% INCREASE IN THE NUMBER OF AMERICANS LIVING AT OR BELOW 125% OF THE FEDERAL POVERTY LEVEL.

THESE TRENDS HAVE LED TO A DE FACTO SHIFT IN THE RESPONSIBILITY FOR PAYING FOR THE HEALTH CARE OF MANY OF AMERICA'S LOW-INCOME PEOPLE. IN 1975, MEDICAID PURCHASED HEALTH SERVICES FOR ALMOST TWO THIRDS OF THE NATION'S POOR. TODAY, MORE THAN HALF OF THE POOR AND MEDICALLY INDIGENT EITHER PURCHASE SOME FORM OF PRIVATE HEALTH INSURANCE THEMSELVES OR RELY ON UNCOMPENSATED CARE PROVIDED BY PUBLIC HEALTH DEPARTMENTS AND BY HOSPITALS.

IN ADDITION, A LEGITIMATE CONCERN WITH SKYROCKETING MEDICAL COSTS HAS SPAWNED A SERIES OF GOVERNMENT AND EMPLOYER EXPERIMENTS IN COST CONTAINMENT. THESE COST-CUTTING MEASURES REDUCE THE ABILITY OF HOSPITALS TO CHARGE PAYING PATIENTS MORE IN ORDER TO SUBSIDIZE CARE FOR THOSE UNABLE TO PAY. THESE CROSS-SUBSIDIES (CHARGING MORE TO MEDICARE OR OTHER THIRD PARTY PAYERS TO MAKE UP FOR BAD DEBT OR CHARITY CARE LOSSES) WHICH TRADITIONALLY HAVE MADE INDIGENT CARE POSSIBLE ARE RAPIDLY DRYING UP.

THE BIGGEST FEDERAL PROGRAM--MEDICARE--SWITCHED TO A PROSPECTIVE PAYMENT SYSTEM BASED ON DIAGNOSIS-RELATED GROUPS (DRG'S) WHICH PROVIDES A FLAT PAYMENT TO HOSPITALS BASED ON THE PATIENT'S DIAGNOSIS. THIS PAYMENT SCHEME MAKES NO ALLOWANCE FOR CHARITY CARE OR FOR COST-SHIFTING.

THE HOSPITALS' ABILITY TO COST-SHIFT IS FURTHER CONSTRAINED BY THE UNPRECEDENTED RECENT EFFORTS OF OTHER THIRD PARTY PAYERS, SUCH AS INSURERS AND EMPLOYERS, TO CONTAIN THEIR OWN HEALTH CARE COSTS. TRADITIONALLY, PRIVATE INSURERS PAID A 10.6% AVERAGE SURCHARGE TO SUBSIDIZE CHARITY CARE. AS HEALTH MAINTENANCE ORGANIZATIONS, PREFERRED PROVIDER ARRANGEMENTS, AND OTHER CAPITATED AND DISCOUNTED CARE ARRANGEMENTS PROLIFERATE AND EMPHASIS ON KEEPING

COSTS LOW GROWS, THESE EXTRA PREMIUMS DISAPPEAR SO HOSPITALS HAVE LESS SLACK TO ABSORB INDIGENT CARE.

COST CONTAINMENT HAS PRODUCED ANOTHER SERIOUS SIDE-EFFECT. COST CONTROL HAS BECOME A DRIVE TO REDUCE WORKERS' HEALTH BENEFITS THAT HAVE BEEN PAINSTAKENLY NEGOTIATED OVER THE YEARS. EMPLOYER AFTER EMPLOYER HAS COME TO THE BARGAINING TABLE DEMANDING THAT WORKERS PICK UP A PORTION OF HEALTH PREMIUMS OR SACRIFICE COVERAGE. THESE COST CONTAINMENT MEASURES LEAVE WORKERS DANGEROUSLY UNDERINSURED.

WHO CAN FORETELL THE EFFECT ON THE OVERALL HEALTH OF AMERICANS OF THE 300% INCREASE IN SUBSTANTIAL DEDUCTIBLES SHOWN IN RECENT STUDIES OF PRIVATE HEALTH PLANS?

THE PROPOSALS TO SHIFT COSTS TO EMPLOYEES HAVE NOT BEEN RESTRICTED TO RELATIVELY WELL-PAID INDUSTRIAL WORKERS, EITHER. SEIU HAS FACED PROPOSAL AFTER PROPOSAL TO INCREASE COSTS OR REDUCE COVERAGE IN CONTRACTS COVERING SUCH LOW-WAGE WORKERS AS NURSING HOME EMPLOYEES, CUSTODIAL STAFF, AND CLERICAL WORKERS. BECAUSE HIGHER DEDUCTIBLES, TWO-TIERED PREMIUMS AND CO-PAYS COME OUT OF THE POCKETS OF WORKERS WHO ARE ALREADY STRAPPED, THESE WORKERS OFTEN FAIL TO SEEK NEEDED MEDICAL CARE.

FINALLY, THE GROWTH OF THE SERVICE SECTOR HAS CREATED AN UNINSURED WORKFORCE. A RECENT HHS STUDY (MONHEIT ET. AL., 1985) SHOWED THAT 75% OF THE UNINSURED ARE WORKERS OR THEIR DEPENDENTS. THESE WORKERS EARNED LOW WAGES AND WERE CONCENTRATED IN SERVICE INDUSTRIES. FOR EXAMPLE, 4.8% OF MANUFACTURING WORKERS WERE UNINSURED ALL YEAR COMPARED TO 16% AND 18% IN THE FAST-GROWING PERSONAL SERVICES AND ENTERTAINMENT AND RECREATION INDUSTRIES.

BETWEEN 1979-1985, SERVICE JOBS INCREASED A HEFTY 13%, CREATING 9 MILLION NEW JOBS. BY CONTRAST, MANUFACTURING EMPLOYMENT SHRUNK BY 8% DURING THIS PERIOD.

H.R. 4742 PROVIDES STRONG INTERIM MEASURES TO IMPROVE ACCESS TO CARE

H.R. 2724 FILLS SOME OF THE BIG HOLES IN THE NATION'S HEALTH INSURANCE SYSTEM.

THE BILL'S EFFORT TO EXTEND HEALTH COVERAGE FOR LAID-OFF WORKERS AND THEIR DEPENDENTS FOR UP TO FOUR MONTHS IS ESPECIALLY ATTRACTIVE. NEW FEDERAL LEGISLATION PROVIDES FOR UP TO 18 MONTHS CONTINUATION OF BENEFITS TO LAID-OFF WORKERS. TODAY, 31 STATES REQUIRE THAT EMPLOYERS PROVIDE LAID-OFF WORKERS THE OPTION TO CONVERT TO INDIVIDUAL INSURANCE. STILL, THIS IS NOT ENOUGH. STUDIES SHOW THAT UNEMPLOYED WORKERS DO NOT TAKE ADVANTAGE OF CONTINUATION AND CONVERSION OPTIONS. FOR EXAMPLE, THE MICHIGAN STUDY OF UNEMPLOYED WORKERS FOUND THAT TWO-THIRDS GOT NO REPLACEMENT INSURANCE, LESS THAN 1% CONVERTED TO INDIVIDUAL HEALTH COVERAGE AND 17% DID NOT EVEN TRY TO SEEK MEDICAL CARE. MILLIONS OF UNEMPLOYED MUST CHOOSE BETWEEN PAYING RENT, EATING OR MEDICAL CARE--A CHOICE NONE OF US IN THIS COUNTRY SHOULD HAVE TO MAKE.

H.R. 4742 PROVIDES UP TO FOUR MONTHS OF EMPLOYER-PAID COVERAGE. THIS IS ENOUGH TO BRIDGE THE GAP FOR NEARLY THREE-QUARTERS OF THE UNEMPLOYED SINCE THE AVERAGE SPELL OF UNEMPLOYMENT IS THREE MONTHS. JUST AS UNEMPLOYMENT INSURANCE PROTECTS WORKERS AND THEIR FAMILIES AGAINST LOSS OF INCOME DURING A PERIOD OF TEMPORARY UNEMPLOYMENT, ENACTMENT OF THIS PROPOSAL WOULD ENSURE TEMPORARY PROTECTION AGAINST THE DEVASTATING COST OF UNINSURED ILLNESS.

HOWEVER, WE WOULD ALSO LIKE TO SEE PAID-COVERAGE EXTENDED TO THOSE INVOLUNTARILY CONVERTED TO PART-TIME WORK. A SHARP CONTRACTION IN HOURS WORKED IS CONCEPTUALLY NO DIFFERENT FROM A LAYOFF; IT OFTEN INVOLVES SUBSTANTIAL EARNING LOSSES AND MAY AUTOMATICALLY SHUT OFF HEALTH BENEFITS, AND IT IS A PRELUDE TO FULL-SCALE LAYOFFS.

UNFORTUNATELY, IT HAS ALSO BECOME AN EMPLOYER TACTIC FOR OUSTING A UNION. MELLON BANK IN PITTSBURGH, FOR EXAMPLE, HAS CUTBACK SUBSTANTIALLY OUR MEMBERS WORK HOURS, SLASHING WORKERS' AVERAGE WEEKLY TAKE-HOME PAY FROM $200 TO AS LOW AS $38 A WEEK AND TAKING AWAY EMPLOYER-SPONSORED HEALTH CARE. THIS MEASURE WOULD ACT AS A DISINCENTIVE TO EMPLOYERS FROM USING PART-TIME WORK AS AN ANTI-UNION TOOL.

WE ALSO SUPPORT THE USE OF STATE INSURANCE RISK POOLS TO EXTEND HEALTH CARE COVERAGE TO THOSE WHO CAN'T GET INSURANCE. NINE STATES HAVE SUCCESSFULLY ESTABLISHED SUCH RISK POOLS. THEY ARE IMPORTANT IN ASSURING MEDICAL CARE AND PROTECTION FROM BANKRUPTCY TO FAMILIES FACING SERIOUS ILLNESS THAT DO NOT HAVE ACCESS TO EMPLOYMENT-BASED HEALTH INSURANCE.

THROUGH SUCH MECHANISMS, THE STATES CAN GUARANTEE ACCESS TO PRIVATE HEALTH INSURANCE TO ALL INDIVIDUALS, REGARDLESS OF THEIR HEALTH STATUS. CURRENTLY, THERE ARE MANY INDIVIDUALS WHO DO NOT HAVE ACCESS TO EMPLOYMENT-BASED HEALTH INSURANCE AND WHO CANNOT OBTAIN PRIVATE INSURANCE ON THEIR OWN BECAUSE OF PRE-EXISTING MEDICAL CONDITIONS. THIS PROPOSAL WOULD ASSURE THAT THESE INDIVIDUALS HAVE ACCESS TO PRIVATE HEALTH INSURANCE AT REASONABLE RATES.

HOWEVER, WE BELIEVE THAT SOME OF THE DETAILS OF THIS PROPOSAL NEED TO BE IRONED OUT. IN PARTICULAR, WE BELIEVE THAT ALL EMPLOYERS SHOULD SHARE THE COSTS OF THESE STATE POOLS, NOT SIMPLY EMPLOYERS THAT CURRENTLY OFFER INSURED OR SELF-INSURED HEALTH CARE PLANS. OTHERWISE, STATES WILL BE REWARDING THOSE EMPLOYERS WHO CHOOSE NOT TO OFFER ANY HEALTH CARE COVERAGE TO THEIR EMPLOYEES.

SEIU ALSO SUPPORTS THE PROPOSAL TO REQUIRE STATES TO EITHER ESTABLISH PLANS TO FUND THE UNCOMPENSATED CARE OF HOSPITALS OR TO DEVELOP A SYSTEM TO PROVIDE HEALTH INSURANCE TO ALL UNINSURED RESIDENTS. THE BURDEN OF CHARITY CARE FALLS DISPROPORTIONATELY ON CERTAIN HOSPITALS. FIVE PERCENT OF ALL HOSPITALS PROVIDE 37% OF ALL UNCOMPENSATED CARE. THE PUBLIC HOSPITALS ARE THE BIGGEST PROVIDERS -- SUPPLYING OVER ONE-HALF OF THE FREE CARE. MANY OF THESE HOSPITALS ARE IN AREAS OF HIGH UNEMPLOYMENT OR IN RURAL AREAS, WHERE THEY ARE THE PROVIDERS OF LAST RESORT.

ENACTMENT OF THIS PROPOSAL WILL ASSURE THAT SEVERELY ILL PATIENTS RECEIVE THE ESSENTIAL HOSPITAL CARE THEY NEED REGARDLESS OF THEIR ABILITY TO PAY. LIKEWISE, HOSPITALS CAN REST ASSURED THAT FULFILLING THEIR TRADITIONAL MISSION OF PROVIDING CARE TO EVERYONE IN THE COMMUNITY WILL NOT JEOPARDIZE THEIR FINANCIAL WELL-BEING.

HOWEVER, SEIU URGES THE SUBCOMMITTEE TO GIVE CAREFUL CONSIDERATION TO CERTAIN DETAILS OF THIS PROPOSAL. FOR EXAMPLE, FEDERAL STANDARDS NEED TO BE INCLUDED TO INSURE THAT SUCH SYSTEMS DO NOT EXCLUDE SIGNIFICANT NUMBERS OF THE NEEDY THROUGH TOO STRINGENT ELIGIBILITY STANDARDS OR THROUGH THE USE OF CO-PAYMENTS. SIMILARLY, MECHANISMS NEED TO BE DESIGNED TO MAKE SURE THAT PUBLIC AND OTHER HOSPITALS SERVING MAINLY THE POOR AND ELDERLY GET THEIR

FAIR SHARE OF THE FUNDS. THIS WILL AVOID PROBLEMS EXPERIENCED WITH SOME STATE REVENUE POOLS LIKE NEW YORK'S WHERE THE PUBLIC HOSPITALS WERE SHAFTED BY THE STATE'S SCHEME FOR REDISTRIBUTION OF FUNDS.

THIS LEGISLATION ALSO LEAVES THE STATES CONSIDERABLE DISCRETION AS TO THE TYPE OF FUNDING MECHANISM WHICH CAN BE UTILIZED. SEIU BELIEVES THAT HEALTH CARE PROVIDERS, HEALTH INSURERS, AND THE FEDERAL AND STATE GOVERNMENTS ALL SHOULD PARTICIPATE IN ANY FINANCING MECHANISM, IN ORDER TO ASSURE A SUCCESSFUL FINANCING PROGRAM FOR UNCOMPENSATED CARE. WE ARE ALSO CONCERNED THAT THE PENALTY WHICH WOULD BE IMPOSED ON STATES THAT FAIL TO ESTABLISH AN APPROPRIATE SYSTEM--DENYING HOSPITALS IN THE STATE THE RIGHT TO PARTICIPATE IN MEDICARE--IS TOO HARSH. WE URGE THE SUBCOMMITTEE TO EXPLORE OTHER POSSIBLE PENALTIES, SUCH AS DENYING TAX-EXEMPT BONDS FOR HOSPITAL CONSTRUCTION AND EQUIPMENT PURCHASES UNLESS THERE IS AN APPROPRIATE STATE SYSTEM TO HANDLE UNCOMPENSATED CARE.

RESTORING ACCESS TO HEALTH CARE: LONG RUN SOLUTIONS

H.R. 4742 PROVIDES AN IMPORTANT FIRST STEP FOR RENEWING OUR NATIONAL COMMITMENT TO A HUMANE AND RATIONAL HEALTH SYSTEM. BUT MORE WORK MUST BE DONE TO TEAR DOWN THE EXISTING BARRIERS TO HEALTH CARE FOR MANY AMERICANS.

WE MUST QUICKLY TAKE THE NEXT STEPS NEEDED TO FILL IN THE MAJOR REMAINING HOLES IN COVERAGE FOR THE UNINSURED POPULATION.

MOST IMPORTANTLY, WE NEED TO DIRECTLY CONFRONT THE FACT THAT THE WORKING POOR COMPRISE THE LARGEST COMPONENT OF UNINSURED AND UNDERINSURED AMERICANS. MANY LOW-INCOME WORKERS SIMPLY CAN NOT AFFORD TO BUY HEALTH INSURANCE IN THE FIRST PLACE, BE IT INSURANCE THROUGH STATE POOLS SET UP BY H.R. 4742, OR PRIVATE CARRIERS.

WE WILL DO OUR PART. WE ARE FORCING THE INDUSTRY TO CUT COSTS THE RIGHT WAY--THROUGH BETTER MANAGED CARE--WITHOUT SACRIFICING COVERAGE. SEIU HAS DEVELOPED A MODEL COST CONTAINMENT PROGRAM WHICH ACHIEVES THE TWIN GOALS OF CUTTING COSTS AND MAINTAINING BENEFITS.

ALONG WITH PROMOTING SENSIBLE COST-CONTAINMENT, LABOR WILL CONTINUE TO VIGOROUSLY PURSUE THE UNFINISHED GOAL OF EXPANDING COVERAGE TO WORKING PEOPLE WITHOUT HEALTH PLANS AND IMPROVING THE EXISTING BUT OFTEN INADEQUATE COVERAGE OF MANY OTHERS.

IN THIS VEIN, WE WILL BE EXPOSING THOSE EMPLOYERS WHO FAIL TO LIVE UP TO MINIMUM AMERICAN STANDARDS OF PROVIDING DECENT EMPLOYER-SPONSORED HEALTH COVERAGE IN THIS COUNTRY.

FOR EXAMPLE, WE UNDERTOOK A MAJOR MEDIA CAMPAIGN AGAINST HILLHAVEN--A MAJOR NURSING HOME CHAIN--WHICH CAME TO THE BARGAINING TABLE WITH A PROPOSAL TO MAKE NEW HIREES PAY HALF OF THEIR HEALTH PREMIUMS FOR THE DURATION OF THEIR EMPLOYMENT. WE EXPOSED THE FACT THAT THESE CUTS DID NOT ARISE OUT OF HIGHER COSTS, BECAUSE UTILIZATION HAD NOT CHANGED ADVERSELY. IN THE END, WE HELD THE LINE ON HEALTH PREMIUMS AND MANAGEMENT EVEN AGREED TO IMPROVE COVERAGE IN THAT CONTRACT.

IN GENERAL, THE VAST MAJORITY OF AMERICAN EMPLOYERS HAVE ACCEPTED THESE MINIMUM STANDARDS OF EMPLOYER-PROVIDED HEALTH INSURANCE. AND WE RECOGNIZE THAT FOR SOME SMALL EMPLOYERS, THE COSTS ARE PROHIBITIVE. BUT WE MUST DO MORE TO EXPOSE THAT SMALL GROUP OF RECALCITRANT EMPLOYERS WHO HAVE STEADFASTLY REFUSED TO LIVE UP TO THEIR OBLIGATIONS TO PROVIDE DECENT HEALTH COVERAGE.

WE WILL ALSO EXPAND HEALTH COVERAGE THROUGH NEW ORGANIZING INITIATIVES AMONG LOW-WAGE SERVICE WORKERS. WE WILL CONTINUE TO ORGANIZE NURSING HOME AND OTHER SERVICE WORKERS IN THE SOUTH AND NEGOTIATE HEALTH COVERAGE FOR THEM AND THEIR FAMILIES FOR THE FIRST TIME.

HOWEVER, THIS WILL NOT HELP THE MILLIONS OF UNORGANIZED WORKERS EXCEPT THROUGH THE SPILL-OVER EFFECTS OF UNION BENEFIT PROGRAMS BEING DIFFUSED INTO THE REST OF THE PRIVATE SECTOR.

BUILDING ON H.R. 4742, WE NEED TO MOVE QUICKLY ON TWO FRONTS TO PUT OUR HEALTH CARE SYSTEM BACK ON TRACK.

FIRST, WE NEED TO GRAPPLE FIRMLY WITH THE ISSUE OF HEALTH COVERAGE FOR UNINSURED WORKERS. SEIU STRONGLY URGES CONGRESS TO ADDRESS THE CONCEPT OF MANDATORY PRIVATE HEALTH INSURANCE COVERAGE FOR EMPLOYEES AND/OR MANDATORY TAX MEASURES TO FINANCE EXPANDED PUBLIC CARE. WE RECOGNIZE FULL-WELL THE HOST OF PROBLEMS THAT NEED TO BE DEALT WITH, BUT BELIEVE THAT IT IS THE ONLY TRUE LONG-TERM SOLUTION TO REMEDY THE PROBLEM OF UNINSURED AND UNDERINSURED WORKING AMERICANS.

PROVIDING CARE BEFORE PEOPLE GET SICK IS THE ONLY WAY TO SET UP A RATIONAL HEALTH SYSTEM. MECHANISMS TO FINANCE BAD DEBT AND CHARITY CARE NECESSARILY FOCUS ON HOSPITALIZATION FOR THE SEVERELY ILL. OUT-OF-HOSPITAL SERVICES AND PRIMARY CARE REMAIN UNCOVERED AND INACCESSIBLE TO LOW-INCOME WORKERS.

ALLOWING PEOPLE TO BECOME SICK BEFORE TREATMENT IS AN INHERENTLY EXPENSIVE APPROACH TO HEALTH CARE. MANDATORY PRIVATE INSURANCE WOULD COVER ALL HEALTH SERVICES AND SAVE MONEY IN THE PROCESS.

USING TAX FINANCING TO SUBSIDIZE MANDATORY PRIVATE COVERAGE OR TO FINANCE FEDERAL/STATE PUBLIC SYSTEMS FOR LOW-INCOME PEOPLE MAKES JUST AS MUCH SENSE TODAY AS IN 1965. STATES AND EMPLOYERS WON'T BE ABLE TO SOLVE OUR NATIONAL PROBLEM ALL BY THEMSELVES. STATES WITH A LARGE UNINSURED POPULATION TEND TO HAVE LESS TAX REVENUES. WE MUST LOOK TO AN EXPANDED FEDERAL ROLE TO ENSURE EQUAL ACCESS TO HEALTH CARE BY ALL. A CHILD IN LOUISIANA HAS A RIGHT TO GOOD HEALTH, JUST AS A CHILD IN NEW YORK DOES.

SECONDLY, WHILE POOLS TO SHARE COSTS FOR CHARITY CARE WILL REDUCE THE PRESSURES ON HOSPITALS THAT SERVICE A DISPROPORTIONATE SHARE OF THE ELDERLY AND POOR, THIS BILL DOES NOT ADDRESS THE LONG-TERM IMPACTS OF HEALTH CARE COMPETITION TRANSFORMING THE INDUSTRY INTO A SYSTEM BASED ON ABILITY TO PAY. INSTEAD OF GIVING US EFFICIENT, AFFORDABLE CARE, COMPETITION IS FUELING THE RACE TO CONSOLIDATE THE PRODUCTION OF HEALTH CARE IN THE HANDS OF A FEW NATIONAL AND REGIONAL FOR-PROFIT CHAINS. THE STATISTICS ARE DISTURBING. FOR EXAMPLE, LARGE CORPORATIONS TODAY CONTROL 15% OF U.S. HOSPITALS AND PLAN TO DOUBLE THEIR MARKET SHARE BY 1990. A PARALLEL TREND EXISTS IN THE NURSING HOME INDUSTRY WHERE THE CHAINS MAY COMMAND A 60% MARKET SHARE BY THAT TIME.

ARMED WITH VAST ECONOMIC POWER, THESE CHAINS ARE RAISING THE COSTS OF CARE; "SKIMMING OFF" THE MOST PROFITABLE PATIENTS, SERVICES AND LOCATIONS; DIVERSIFYING INTO OTHER HEALTHCARE BUSINESSES; AND MAKING A BUNDLE IN THE PROCESS.

THE MOVES BY GIANT HEALTH CARE CORPORATIONS TO SEGMENT THEIR MARKETS TO INCREASE PROFITABILITY INCREASINGLY PUTS HOSPITALS THAT PROVIDE EMERGENCY AND OBSTETRICS CARE AND OTHER LOW-PROFIT MEDICAL

SERVICES OR WHICH ARE THE DUMPING GROUNDS FOR THE UNINSURED AND POORLY INSURED AT A STRONG COMPETITIVE DISADVANTAGE. FOR-PROFIT CORPORATIONS ARE FAST DRIVING MANY OF THE FINANCIALLY-STRAPPED PUBLIC AND COMMUNITY HOSPITALS INTO BANKRUPTCY. INTERESTINGLY, THESE HOSPITALS OFTEN ARE LESS COSTLY. THEIR ONLY CRIME IN THE MARKETPLACE IS TO SERVICE "UNPROFITABLE" PATIENTS.

EVEN THE NON-PROFITS ARE IMITATING THE CHAINS--MERGING TOGETHER, SETTING UP FOR-PROFIT SUBSIDIARIES TO SELL SERVICES RANGING FROM HOME HEALTH TO REAL ESTATE AND LIMITING THEIR CHARITY CARE.

OVER THE LONG HAUL, THESE CHANGES IN THE STRUCTURE OF THE INDUSTRY SPELL LESSENING COMPETITION, HIGHER LEVELS OF HEALTH SPENDING, AND REDUCED ACCESS TO CARE.

STATE PLANS TO FINANCE UNCOMPENSATED CARE, AS IN H.R. 4742, WILL WORK TO DAMPEN SOME OF THE ADVERSE EFFECTS OF COMPETITION BY IMPROVING ACCESS TO EMERGENCY HOSPITAL SERVICES.

HOWEVER, MORE MUST BE DONE TO ATTACK THIS ROOT PROBLEM. MORE FUNDAMENTALLY, CONGRESS NEEDS TO REEXAMINE ITS EXPERIMENTS IN PROMOTING HEALTH CARE COMPETITION TO MITIGATE ANY ADVERSE IMPACTS ON ACCESS TO HEALTH CARE. AS CONSUMERS, WE ARE ALL CONCERNED BY SKYROCKETING MEDICAL BILLS. SEIU, AND ALL OF ORGANIZED LABOR, HAS CALLED FOR YEARS FOR MEANINGFUL CONSTRAINTS ON HEALTH CARE COSTS. WE OPPOSE THE DOUBLE-DIGIT INFLATION AND THE HIGH LEVEL OF RESOURCES--11% OF GROSS NATIONAL PRODUCT--NEEDED JUST TO PROVIDE THE BARE MINIMUM OF HEALTH SERVICES, NEVER MIND UNIVERSAL CRADLE-TO-GRAVE COVERAGE OTHER COUNTRIES ENJOY.

WE ARE PREPARED TO ACCEPT COMPETITION AS A WAY TO BRING DOWN COSTS, BUT ONLY IF IT IS MEANINGFUL COMPETITION AND ONLY IF FEDERAL

FUNDS ARE SUFFICIENT TO PROVIDE FOR THE PUBLIC HEALTH OF THOSE LEFT OUT OF THE SYSTEM BY COMPETITION.

IN THIS VEIN, CONGRESS SHOULD CONSIDER A BROADER PLAN THAT COMBINES STATE POOLS TO FINANCE HEALTH CARE WITH AN ALL-PAYOR STATE RATE-SETTING SYSTEM. THE AFL-CIO'S NEWLY-FORMED COMMITTEE ON HEALTH HAS PUT FORWARD MODEL STATE LEGISLATION TO SET HOSPITAL RATES AND POOL FUNDS FOR INDIGENT CARE. RATE-SETTING SYSTEMS AND STANDARDS FOR QUALITY SERVICE ARE ESSENTIAL TO STOPPING MARKET SEGMENTATION AND PROFITEERING IN THE HEALTH ARENA.

IN ADDITION, WE MUST PROVIDE MORE FEDERAL FUNDS TO THE POOR LEFT BEHIND BY COMPETITION. A RECENT STUDY (BLENDON ET. AL., 1986) CONFIRMS THAT UNCOMPENSATED CARE IS A POOR SUBSTITUTE FOR PUBLIC HEALTH PROGRAMS AND MAY ADVERSELY AFFECT HEALTH CARE RECEIVED BY THE POOR. THE ANALYSIS SHOWED THAT LOW-INCOME PERSONS RECEIVED SUBSTANTIALLY LESS CARE FROM PHYSICIANS IF THEY RESIDED IN STATES WITHOUT MEDICAID PROGRAMS OR WITH ONLY LIMITED PROGRAMS. IN ARIZONA, THE ONLY STATE WITHOUT A MEDICAID PROGRAM, POOR CHILDREN SAW PHYSICIANS 40 PERCENT LESS OFTEN THAN POOR RESIDENTS OF STATES WITH MEDICAID PROGRAMS.

ONE SOLUTION WOULD BE TO REVAMP THE MEDICAID PROGRAM SO THAT IT SERVES THE TRULY NEEDY BY PROVIDING FEDERAL ELIGIBILITY STANDARDS COUPLED WITH INCREASED FEDERAL FUNDING.

MIXING TOGETHER THESE DUAL PROBLEMS--COMPETITION'S SEGMENTATION OF MARKETS FOR HIGHER PROFITS AND HISTORIC RATES OF UNINSURED AND INADEQUATELY INSURED WORKING FAMILIES--YIELDS A NATIONAL RECIPE FOR PAIN AND POOR HEALTH.

MULTIPLE PROBLEMS REQUIRE MULTIPLE SOLUTIONS. IF WE WORK IN CONCERT--UNIONS, EMPLOYER GROUPS, HEALTH CARE ASSOCIATIONS, AND CONGRESS--WE CAN DEVELOP A NATIONAL STRATEGY TO EQUALIZE ACCESS TO THE HEALTH CARE SYSTEM FOR ALL OUR CITIZENS. AND WE CAN TOGETHER BUILD A STRUCTURE THAT PROVIDES HEALTH CARE AT REASONABLE COSTS. ALL OF AMERICA'S CITIZENS--WORKERS, THE UNEMPLOYED, THE DISABLED, THE ELDERLY--HAVE A RIGHT TO DECENT, AFFORDABLE HEALTH CARE.

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Testimony of
The Society of Professional Benefits Administrators (SPBA)
Subcommittee on Health
on HR 4742, The Health Care Improved Access Act of 1986
June 9th, 1986
by: Frederick D. Hunt, Jr., SPBA President

The Society of Professional Benefit Administrators (SPBA), founded in 1975, is the national association of independent third party contract benefit administration firms. It is estimated that one third (1/3) of all U.S. workers are covered by employee benefit plans administered by such firms.

SPBA members operate much like independent CPA or law firms... providing continuing professional out-of-house claims and benefit plan administration for client employers and benefit plans. Most of the plans employ at least some degree of self-funding. Client plans include those sponsored by corporations of all sizes, associations, and union/management jointly-administered Taft Hartley multi-employer plans.

SPBA membership has grown almost 700% in the past 6 years... with a current roster of almost 400 member firms. Similarly, SPBA members have seen the market for their services also expand rapidly...in large part because of the leading role of SPBA members have played in successful health cost containment efforts and cost-efficient administration techniques for pension and health benefit plans.

Mr. Chairman and members, we are sorry that a more thorough hearing of the concerns over this legislation could not be heard, but we appreciate this opportunity to submit written testimony...and hope that it will be heeded.

SPBA brings one of the most comprehensive perspectives of employee benefit issues. It is estimated that one-third (1/3) of all U.S Workers are covered by plans administered by SPBA member Third Party Administration (TPA) firms. These plans cover every size and format of employment. Thus, our comments are not geared to one size or type of i-dustry, and include both unionized and non-union employees.

We submit as our testimony on this bill the following points. I understand that these forecasts and comments are consistent with the feedback your staff have been receiving from plan sponsors and employers around the country.

1. "BIG BROTHER"...in its most unkind connotation....is the perception given when Congress decided to supercede the intelligence and rights of workers and employers to determine the most appropriate benefit package in each employment circumstance. This philosophical objection to this intrusion has raised deep resentment across the country.

2. LOSS OF BENEFITS will occur in order to pay for this and other new Federally-mandated benefits. Money contributed for employee benefits does not come from a bottomless pit. Only a set amount will be dedicated for that purpose. Therefore, if the requirements of this kind of legislation are mandated...then something else desired by the workers will be killed or drastically cut back to make up for the cost of the new mandated benefit. Pensions, vision, dental, or disability coverage are likely first victims.

John Timmer, Chairman of the Board — Employee Services, Inc., Sioux Falls, SD
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3. TERMINATION OF WHOLE BENEFIT PLANS is quite likely and logical. This legislation is not operating in a vacuum. There are half-a-dozen major expensive Federally-mandated benefits or cost-shifting from government programs to private employee benefits this year. Not only does this mean billions of dollars of extra cost for employers (or off-set lowered/terminated benefits)... but every year major new expensive administrative hassles are added for plans and sponsors. For these reasons...and because government policy chooses to punish only employers who are already voluntarily seeking to aid their employees and families...Uncle Sam is actually strongly encouraging the termination of all employee benefits, since that is the only way to escape the laws and expense.

4. PAYING FOR UNRELATED PERSONS is directly contrary to longstanding Federal employee benefits policy. Both ERISA and the tax code have stringently limited coverage to those who have a "direct employer-related bond". If coverage for unrelated people is a desired public goal...then it should be spread over all of society via a public tax.

5. FORCING STATES to operate in a certain way (pools & charity reimbursement) within an area which is specifically delegated to the states under the Federal McCarran-Ferguson Act provides an interesting question of constitutional law and strongarm tactics. Punishing employers if (beyond the employer's control), the state does not go along with this tactic is an even more aggravating frustration.

6. POOL BANKRUPTCY is almost assured to be a routine occurrence, since the funding conditions are being set politically in Washington D.C. rather than actuarially in the states where the local conditions are known. In the case of such bankruptcies, employee benefit plans will be hit with extra assessments for which they had no way (or authority under the tax code) to prepare. For the 40+% of Americans covered by self-funded plans, the Tax Reform Act of '84 (DEFRA) sections relating to VEBA reserves must be drastically changed... or else prepare for the plans to bankrupt due to Federal mis-planning.

7. MORE MONEY THAN UNCLE SAM ENVISIONS is at stake for employee benefit plan sponsors. Not only is there the initial extra money for state pools, and then an extra assessment when those pools routinely go broke...but there is also the vague description of reimbursement for what is now charity care. Even the proponents of this legislation claim that that is a huge potential sum of money. Presumably, this money will also come from employee benefit plans (thus causing still more cut-backs and terminations of desired coverage)...or from state budgets. It should be noted that Uncle Sam's generosity...which will probably end up costing states directly and indirectly...comes at a time when the Congress is also considering cutting the state-tax deduction on Federal income tax forms. Thus, state taxes will have to rise by Federal fiat... and then might not be deductible.

8. HMOs, BLUE CROSS, SELF-FUNDED, & GOVERNMENTAL PLANS WILL BE CHEATED. While insurance companies have been participating in state pools in less than 20% of the states, as part of their desired regulation by state governments... it must be remembered that such contributions to state pools are fully deductible and often off-sets of premium taxes in those states. However, HMOS, Blue Cross, self-funded, church, and city/state governmental plans are non-profit and thus neither have the tax deduction nor the premium tax off-sets. Thus, this provides a distinct price disadvantage to the non-profit groups.

9. HYPOCRITICAL seems the best description of the proposed HHS commission to encourage small businesses to lower health coverage costs and provide benefits. As noted, this legislation and the many other unrelated well-intentioned-but-counter-productive mandates and cost-shiftings are simply nails in the coffin of employer willingness (especially smaller cash-flow-sensitive ones) to help provide for their employees. There is also skepticism that any such Commission action would either be prejudiced from the start...or too late in coming to reverse the legislation.

Again, we appreciate the opportunity to have some input into this legislation. We urge you to look beyond the mirage of instant benefit...to the real effects for the intended beneficiaries and for society as a whole. If we can be of assistance, please do not hesitate to call upon us.

State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICES
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EXECUTIVE SUMMARY

REPORT ON HEALTH CARE COVERAGE FOR WORKING-AGED PERSONS WITH PHYSICAL DISABILITIES: A KEY TO REDUCING DISINCENTIVES TO WORK

Many persons with disabilities have difficulty obtaining access to health insurance for their health care needs. They are squeezed between (1) Social Security regulations which deny eligibility for Medicare and Medicaid to persons with the ability to work, (2) standard group insurance policies which do not cover on-going health maintenance needs, (3) employers who do not contribute to health insurance, and (4) insurance companies which do not provide coverage for persons with certain physical or mental conditions. As a result, many persons with disabilities cannot obtain the health care coverage they need if they are employed.

This study utilizes an anonymous sample of 437 working-aged persons with physical disabilities randomly selected from different categories within Wisconsin's Division of Vocational Rehabilitation (DVR) information system and participants of Wisconsin's five Independent Living Centers (ILCs) to examine the relationship between health care costs, health insurance coverage, and employment. It was found that persons with higher health care costs and more unstable health conditions were less likely to enter the labor force or earn over $300 per month than other persons with disabilities at the same level of education for whom health care was less of a problem. In addition, approximately twenty percent of the study sample claimed to have limited their work efforts in order to avoid losing Medicaid or Medicare.

While society's capacity for rehabilitation has greatly increased, many people with disabilities are afraid that they may not be eligible for publicly-funded health care if they demonstrate the capacity to work. Recent developments in medical technology and expanded public commitments to provide public education for all persons and to remove architectural barriers to participation in the mainstream could increase the labor force participation of persons with disabilities. However, the Social Security Administration's continued use of an earnings test to determine whether a person with severe, continuing medical impairments can engage in "Substantial Gainful Activity" (SGA) creates a substantial disincentive to work. If a person can earn more than $300 in gross monthly wages or approximately $70 per week (which is considerably less than even minimum wage to say nothing of the health care expenses of many persons with disabilities), he or she may not be considered legally disabled, and therefore may not be eligible for Medicare or Medicaid. As long as their access to health care coverage is dependent on earning less than SGA, many persons with disabilities cannot afford to work.

Recognizing that a permanent disability does not disappear when one begins to earn $300 per month, only 13.6 percent of working-aged persons with severe limitations enter the labor force according to the SSA's Survey of Disability and Work in 1978. This compares with a labor force participation rate of 82.6 percent for persons without disabilities. Even among those people who DVR rehabilitated to jobs earning above the SGA level, only 36.9 percent of the SSDI clients and 25.5 percent of the SSI clients were still earning above $70 per week after nine months. Another 30% of the SSI and SSDI clients in this group continued working after DVR placement but earned less than $70 per week. An examination of Wisconsin's DVR information system between 1980-1984 reveals that there has been no increase in the rate of vocational placements for persons with physical disabilities on SSI or SSDI in spite of various work incentives incorporated in the Social Security Act since 1980. Moreover, while 26 percent of DVR's clients in 1984 were on SSI or SSDI, only 3.1 percent of persons who DVR placed in jobs earning over $70 per week were on SSI or SSDI. While the loss of health care coverage is clearly not the only disincentive to work, this study provides empirical evidence that many persons are afraid to demonstrate their capacity to work for fear of jeopardizing their eligibility for publicly-funded Medicaid or Medicare.

Health care coverage is particularly important to persons with disabilities who are more likely to have higher health care costs, greater health care utilization, and lower incomes than persons without disabilities according to various national surveys. An examination of a Wisconsin sample of 104 Medicaid recipients with various physical disabilities identified through the DVR system, indicated that in 1984 approximately one-third required some hospitalization, although the health care costs and the type of services needed varied widely among disability groups. But although persons with disabilities have higher average health care costs than persons without disabilities, only a small sub-set of persons with disabilities actually have unstable health conditions and extremely high health care costs. Nevertheless, many persons with disabilities are denied access to health insurance altogether or charged prohibitively expensive premiums because of their pre-existing conditions.

For persons with disabilities who were not employed, Medicare covered 54.5%, Medicaid covered 36.9%, and 17.6% were covered by group policies through a spouse or a parent within the DVR/ILC sample. Among persons with disabilities who were employed, most received group insurance through their own employers (43.2%) which actually increased to 73.2% for those who worked at least 40 hours per week. Small employers with clerical, sales, or service workers, paying low wages, and using part-time employees in high turnover jobs were least likely to offer group insurance policies. Individual policies from health insurance companies covered only 5.9 percent of those employed and 9.0% of those not employed. Similar to the uninsured in the general population, those without any health insurance included 14.4 percent of those who were employed and 9.0 percent of those not employed.

To reduce the disincentives to work and lower the financial burden of health care costs on persons with disabilities who choose to work, this report examines the strengths and limitations of various options to improve access to health care coverage for persons with disabilities. Among the options which can be implemented by state government are a combination of insurance strategies to influence the practices of insurance companies, health care providers and employers, and public financing strategies to redistribute the costs of health care. These include:

A. 1619(b) Work Incentives for SSI Recipients:

One of the most important work incentives which Congress created in the 1980 Social Security Amendments is the "1619" program. 1619(a) allows SSI recipients to continue receiving SSI cash payments after they begin engaging in substantial gainful activity (SGA) up to the SSI "break-even point." In Wisconsin, the SSI break-even point is $960.40 as of January 1985 which includes the state SSI supplement. 1619(b) permits SSI eligible persons to retain Medicaid coverage eligibility if they continue to need Medicaid services in order to work, and if their income is not sufficient to purchase the needed medical services. In Wisconsin, SSI recipients who earn up to $15,871 per year may retain their Medicaid coverage. But in spite of the availability of these health care supports, only 129 persons throughout Wisconsin were participating in 1619(b) in September 1985. This low rate of participation may be due to inadequate outreach by the Social Security Administration, lack of coordination between SSA claims representatives and rehabilitation staff, and fear among SSI recipients that they may lose their Medicaid coverage when the temporary 1619 program is scheduled to expire on June 30, 1987. Outreach could be greatly improved by SSA using its computer system to identify SSI recipients with various levels of earnings and sending them comprehensible information about 1619 along with their SSI checks. Wisconsin's Bureau of Social Security Disability Insurance could also inform persons when they are notified about their eligibility for SSI about the availability of 1619 work incentives. Moreover, SSI Field Offices could periodically circulate a notice to all agencies involved with SSI recipients to inform them about SSA's availability to conduct training on 1619 for agency staff. Furthermore, Wisconsin can support legislative efforts in Congress to make permanent and strengthen this work incentive program and to extend comparable work incentives to the larger group of SSDI beneficiaries.

B. Personal Care Assistance (PCA):

A PCA program can remove a critical obstacle to employment for persons who need attendant care for bathing, dressing, transferring, and bowel and bladder care. Some states have developed a state-funded PCA program targeting persons with physical disabilities who need more assistance than can be purchased through Supportive Home Care which is funded by Social Services Block Grant funds. Other states are funding Personal Care as a Medicaid optional service for persons who can direct their own care. Personal Care can be more cost-effective than Medicaid-funded home health care services provided by a certified home-health agency. To take advantage of this potential efficiency, Minnesota certifies PC attendants as individual Medicaid providers while Massachusetts uses Independent Living Centers as a Medicaid-certified agency to pass through Medicaid dollars for individual consumers to pay their own attendants. In both models, Medicaid has been used to reinforce consumer control. While a state-funded PCA program offers more flexibility in targeting resources to certain populations, a Medicaid-funded PCA program would tap federal

Medicaid dollars and enable 1619 recipients to be eligible for PCA services while they are employed earning up to the state's 1619 threshold.

Although the study sample targeted persons with orthopedic disabilities, fewer than 20 percent needed any paid personal care. It has been estimated that only 150 working-age persons per one million population need fourteen hours or more of attendant care each week.

C. Pools:

If persons with disabilities are separated from the general population and concentrated in a high risk pool, their average health care costs are likely to be much higher than they can individually afford. The insurance principle is based on sharing risk among persons with high needs and low needs to arrive at a premium that all persons can afford. For employer groups with over twenty-five employees, insurance companies do not generally consider the health care needs of specific individuals in developing a group policy. As a result, the health care costs for persons with disabilities would be shared within the group and distributed among those who use less health care services than they pay for through their standard premiums. However, insurance companies may examine the health care needs of individuals who seek individual policies or attempt to join a group with fewer than twenty-five employees. Insurance companies and employers are also allowed to exclude from group coverage employees who work less than full time. By trying to recover their costs and make a profit from each individual or small group where the capacity to share risks is much lower, the insurance company protects itself from "adverse selection" by demanding a higher premium, excluding pre-existing conditions, or rejecting entirely the person with disabilities. As competition among insurance companies has led to the replacement of an average "community rating" by "experience rating" for different groups based on various indicators of risk, persons with higher needs are forced to gravitate to high risk pools which require government support.

1. High Risk Pools

Nine states, including Wisconsin, have a high risk comprehensive insurance pool for persons who have been rejected by two or more insurance companies. By concentrating high risk persons in the same pool, the premiums, deductibles, and co-insurance payments can be as high as $4,000 per year which are prohibitive to many low income persons with disabilities. Wisconsin is the only state which offers a modest premium subsidy for low income policyholders in the high risk pool. To finance the expenses which the high risk pool pays out beyond the individual premiums and the small state premium subsidy, insurance companies and HMOs are subject to an assessment in proportion to the volume of business which they conduct in the state. This unique funding arrangement does distribute some of the costs among all insurance policyholders in the state. However, self-insured employers who comprise the largest employers and account for at least 40 percent of the work force are exempt from the state requirement to contribute to the high risk pool by the federal Employee Retirement and Income Security Act (ERISA). As a result, there is great pressure from the insurance industry to limit the range of services which are covered by the high risk comprehensive policy and to require high risk policyholders to pay higher out-of-pocket costs. While this high risk pool provides an important service especially to older persons who cannot purchase individual insurance because of catastrophic illness, the existing high risk pool is likely to be both too expensive and too limited in coverage for many working persons with disabilities. It may be necessary to modify the existing high risk pool or create another high risk pool to accommodate the health care needs of persons with disabilities who are employed. Benefits would need to be expanded to more fully cover ongoing maintenance services for chronic disabilities, and strategies would have to be developed to distribute costs more equitably among all insurance policyholders and self-insured employers. In addition, state subsidies could be increased and expanded to the deductibles and co-payment requirements of low-income persons. Variations in deductible levels, premiums, and range of services could also increase the attractiveness of this high risk pool to more persons.

2. Uninsured Pools

The State of Wisconsin is considering the development of a State Health Insurance Program (SHIP) to provide health care coverage to an estimated 10.2 percent of the state population which is uninsured. Insurance for those in the SHIP pool could be funded by a combination of private premiums paid on a sliding fee scale, employer contributions, publicly subsidized premiums based on income or medical expenses, and assessments on insurance companies, HMOs, hospitals, doctors, drug companies, and other health care providers. If SHIP is able to create a sufficiently large pool of many persons with low risk, it may be feasible to include persons with disabilities in this SHIP pool to distribute their higher health care costs. Among the uninsured who are likely to have low risks and might be available for a SHIP pool include: full-time employees (28.2% of the uninsured in Wisconsin), children under 18 (29.5% of the uninsured in Wisconsin), and households with incomes greater than $25,000 (24.9% of the uninsured in Wisconsin). Other low risk groups without private insurance which could be added to the SHIP pool include AFDC families, General Relief recipients, and workers receiving Unemployment Compensation. If persons with disabilities are excluded from the SHIP pool, they could be covered by an Alternative Plan which the legislature also authorized for development, for persons who it may not be feasible to serve through the standard plan. Persons with disabilities might be able to take advantage of a separate high risk pool or a mechanism for a wrap-around policy to supplement inadequate standard policies if these were made available.

3. Other State Pools

The state might also consider creating larger pools of low risk persons by combining state and county employees, uninsured workers on Unemployment Compensation, AFDC families, and General Relief recipients along with persons with disabilities. Or the state can utilize its expertise to help small employers get access to more affordable group policies by administering separate buying pools through the state's Group Insurance Board for the purposes of soliciting bids for small employers.

D. Supplements or Wrap-Around Policies:

Standard health insurance policies do not generally cover certain ongoing maintenance services which may be needed by persons with physical disabilities. Such services include: attendant care, durable medical equipment purchase or repair, disposable supplies, drugs, and various therapies. A wrap-around policy which covers these services would enable persons with disabilities to supplement standard group or individual health insurance policies. Where it is not feasible to broaden the range of services available to all persons through the standard plan, supplementary wrap-around policies could be available to reduce the exorbitant out-of-pocket expenses which many persons with physical disabilities face for predictable expenses to maintain their basic health. Wrap-around policies could be provided through commercial insurance channels funded by employer contributions, a sliding-scale premium, and a public subsidy, or perhaps could be provided through public mechanisms like a Medicaid buy-in plan. The State could request a waiver to utilize Medicaid dollars for paying part of the premium for Medicaid eligible persons while their employers or they contribute to the premium on a sliding fee basis. Key to the utilization of a Medicaid buy-in plan is the comprehensiveness of Medicaid services which are not available through commercial insurance policies. It might also be possible to develop separate funding mechanisms with public participation for disability-related costs while non-disability related costs are handled by private insurance mechanisms.

E. State Re-Insurance Mechanisms:

Insurance companies redute their risks by purchasing re-insurance policies from other insurance companies. These re-insurance arrangements cover losses above a certain level. Where the level of risk is uncertain, the state can provide its own re-insurance mechanism to protect the liability of insurance companies or HMOs covering populations which they do not have experience with. To attract HMOs to participate in Wisconsin's pilots to serve AFDC families and General Relief recipients, Wisconsin's Department of Health and Social Services has utilized a state re-insurance mechanism to cover the hospitalization costs of enrollees above a certain level. These re-insurance mechanisms can be extended to cover outpatient and in-home services to reduce the private risk of insurance companies and HMOs which cover persons with disabilities.

F. Insurance Statutes:

Although insurance companies are not obligated to provide health insurance to people who need it, there are certain regulations which insurance companies must observe.

1. Mandated service

The state mandates that certain services be included in group health insurance and HMO policies as well as in individual Medicare supplementary policies. Wisconsin Statute 632.895 requires that every health insurance policy which provides benefits for inpatient hospital care must provide coverage for at least 40 home health care visits per year. Home health care may include intermittent home nursing care, home health aide services, various types of therapy, medical supplies and medication prescribed under the home care plan. Coverage may be limited to cases where hospitalization or skilled nursing confinement would be necessary if home care was not provided. A statutory change would be required to extend these mandatory benefits from short-term care to long-term care to accommodate the ongoing maintenance needs of persons with disabilities.

2. Mandated access

The conditions under which an insurance company must provide coverage to a policyholder are regulated by insurance statutes. Insurance companies cannot terminate a policyholder or raise individual premiums because of an individual's medical expenses. A health insurance policy which provides coverage for a member of the insured's family must provide coverage for a child born with disabilities from the moment of birth. The policy shall cover functional repair or restoration of any body part when necessary to achieve normal functioning. (Wis. Stat. 632.895(5). Family coverage for dependents must continue regardless of age limitations specified in the insurance policy as long as the child is incapable of self-sustaining employment because of mental retardation or physical handicap and remains chiefly dependent upon the person insured under the policy for support and maintenance. (Wis. Stat. 632.88(1). Furthermore, persons who have been covered by group health policies have the right of conversion to an individual policy if they become unemployed. (Wis. Stat. 632.897). By examining the characteristics of the uninsured in Wisconsin, it may become apparent how existing coverage can be extended to include those who are presently uninsured. This may require new definitions of the "family" to include all household members and new definitions of "employees" to include those who work part-time or part of the year, and it may require new ways to fund premiums or premium supplements to extend and expand existing coverage.

3. Private right of action

Insurance companies are prohibited from refusing or limiting coverage, or charging a higher rate for the same coverage because of a mental or physical disability unless "based on either sound actuarial principles supported by reliable data or actual or reasonably anticipated experience." (Wis. Stats. 628.34(3)(b). Wisconsin's Office of the Commissioner of Insurance (OCI) provides an administrative process for resolving complaints filed by persons who claim unfair discrimination. Through the administrative process OCI may ask the insurance company for the data which was used to justify its underwriting actions. If OCI decides that the insurance company has discriminated unfairly, it can order the insurance company to change its underwriting practices, impose a fine, or require the insurance company to rewrite its underwriting manual. However, OCI does not have the authority to order an insurance company to insure a particular individual. Some critics believe that insurance companies would be less likely to discriminate on the basis of physical or mental disability if the consumer could sue an insurance company for unfair discrimination and collect attorney fees and court costs if successful.

4. Consumer Information

Many consumers do not know which insurance companies offer the best coverage for their specific condition. A consumer hotline, modeled after the Medigap hotline operated in Wisconsin's Board of Aging and Long-Term Care, could provide reliable information about what is available and counseling for persons with disabilities about their options in seeking adequate health insurance. The capacity of the consumer hotline to keep track of updated information on all insurance policy offerings could be greatly enhanced through the use of a computer. This could provide a useful service to both consumers and insurance agents.

C. Employer Contributions:

Eighty-nine percent of the privately insured population under 65 were enrolled in employment-related group plans in 1977 according to the National Center for Health Services Research. Government wage policy during World War II and subsequent tax policy has created incentives for employers to offer group coverage to their employees. However, many employees working for small employers or working part-time or seasonally or working for low wages do not receive health coverage. As a result, the largest group of uninsured are the families of low-income workers. Most of these persons are prevented from purchasing individual health insurance policies either because of the exorbitant cost or because of pre-existing conditions. In the absence of federal or state requirements that employers contribute to the health care of their employees and their families, the state has to figure out how to insure the uninsured without creating incentives for employers to withdraw their existing contributions. The federal Employee Retirement Income Security Act appears to prevent states from requiring employers to contribute to the health insurance of their employees. However, the State of Hawaii has received an exemption from ERISA and requires all employers to offer a comprehensive health insurance policy to their employees. Hawaii is prepared to subsidize the cost for small employers if the cost exceeds 1.5 percent of the total wage bill or 5 percent of the employer's pre-tax income. As a result, 98.2 percent of the civilian population in Hawaii is covered by health insurance.

H. HMOs and Contracted Managed Care Models:

Recent federal and state policy is favoring the creation of health maintenance organizations (HMOs) to create competition among fee-for-service providers and reverse incentives for unnecessary and costly care. HMOs offer the potential for greater attention to preventive care, more continuity of care with primary care providers, and greater accountability to consumers through the board of directors and to the contracting agency. But it is not known how well the HMO model meets the needs of persons with disabilities. If HMOs are reluctant to refer people out to specialists who are not on their own staff, this may penalize persons with disabilities who have special needs.

While there are no HMOs which target only people with disabilities, many people with disabilities do receive services from HMOs through their employer group plans. The HMO experience of persons with disabilities should be closely examined to see how this model can be better adapted to their needs. In addition, models of contracted care which utilize different case management approaches should be carefully evaluated in order to identify more cost-effective ways to deliver health care services to persons with disabilities which can reduce the need for costly rehospitalization.

Conclusions

Problems with ensuring access to health care coverage for persons with disabilities are likely to be accentuated by changes in public policy designed to contain health care costs. Proposals to tax the employers' contributions to group coverage may reverse the trend toward comprehensive insurance which has tended to broadly distribute risk. If lower risk employees choose catastrophic coverage to reduce their premium costs, this will reduce the pool of low risk persons and increase the cost of health insurance for higher risk persons. Political pressure to create alternatives to Medicaid may also create special problems for persons with disabilities who cannot replace the comprehensiveness of Medicaid in the private market. And the trend toward HMOs may create obstacles for persons with disabilities to get referrals to specialists outside of HMOs. Lastly, the proposed use of Diagnostic Related Groups (DRGs) for Medicare reimbursement of rehabilitative services may limit access to needed services by persons with disabilities. Failure to increase access to health care coverage for persons with disabilities may perpetuate substantial disincentives to work, contribute to more costly risks of rehospitalization, and impose growing financial burdens on persons with disabilities who are employed.

An Advisory Committee within the Department of Health and Social Services is examining the feasibility of each of these options and will identify fiscal, statutory, and administrative requirements for implementing the most promising approaches. This information will be available for the preparation of budget initiatives that can be submitted to the Legislature along with the Department's recommendations for SHIP. Comments and questions should be directed to Bob Griss in the Office for Persons with Physical Disabilities, Room 434, One West Wilson Street, Madison, WI 53707; telephone number: (608) 266-7254.